			For						nd Mental H		200	1. 1	. 15	01
	_		- State Registrar Amended#1		FCHI	, KSCer	uncate of t	Jean	2. Date of	Reg. No Death	,,,,,	•	Time of E	Death
	Physicia		-Catherine	Katheri	ne Si yder	ıyder			Month Decei	Da nber	10,200	ar	. 00A	м
	/Medic Examin		4a. Facility Name (If not institution, ga		,		4b. City, Town, or	Location of			. County of D			
			Frederick Memor	ial Hospit	al		Freder If Under Tyear	rick			Freder	rick		
	Funeral					last birthday) Yrs.	If Under TYear Months Days	Hours 2	Min. (Month,	Day, Year)	9.	Birthplace Country)		Foreign
L	Director	-	Usual Residence of Decedent	A		113.			Nov. 1	1, 19	925 Ma	aryla	nd	
	yland	1	10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. li	nside City	y Limits
	a-fst	ctor	Maryland Freder	ick		Freder	ick					1	Yes	2 🗌 No
	3a or 28	al Dire	10e. Street and Number 90 Waverly Drive	Apt. #305			10f. Zip Code	2170	1		tizen of What Lted St	-		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinet must be notified at once.	y Funeral Director	11. Marital Status 1 □ Never Married 2√2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ↑ If Yes, Give		'	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2√√ No	ispanic Orig an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A Black, W Specify:	merican Ir Vhite, etc. Whit		
21215-0036	hours furel',	ed by	3 Widowed 4 Divorced 15. Decedent's	Year or Dates:			dent's Usual Occup	ation		16h K	(ind of Busine			
5	in 72 n "net	Completed	(Specify only highest g	rade completed)		(Give	kind of work done of the contract of the contr	during most	of working	100.1	and or busine	333/11/0031	y	
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5)+)	Hon	emaker				Own Ho	ome		
Maryland	should be filed within and Mental Hygiene. s marked other then "umatic event, Ins Mex	To Be C	17. Father's Name (First, Middle, Las Charles Kline	st)					's Name <i>(First, Mide</i> .la Garrin		n Sumame)			
ary	shou and M s mar		19a. Informant's Name/Relationship			1	-		or Rural Route Nu				(e)	X
	and 2 ealth n 27 I		Rick Snyder / So				CONTRACTOR OF THE PARTY OF THE	Rd.,	Walkersvi	_				
Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 Deurial 2 Cremation 3	Removal from State	0	emetery, crer	sition (Name of natory or other plac		Date	20c. L	ocation - City	or Town,	State	
Ë	t. Partmen rtant: njury		* 4 □ Donation 5 □ Other (Spec		Res	thaven	Mem. Ga	rden 1	.2/13/04 Stautter	Funer	edericl	k, Ma	ryla	nd
Bal	permi Depa Impo any ir	() at their () allower								Frede	erick,	MD 2	1702	
Н			23a Part Enter the disease or complications that assed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Inte	proximate erval Betw set and D	/een
	Physician	Ì	Immediate Cause (Final disease or condition	_a ME1	ABO	LIC E	EN CEPHANO	PATH	7				day	
П	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	NEPHHOO PAZ FAN					90	cles	
		. G	Sequentially list conditions,	b. Cue to (or as	a conseq	uanca of):	AL FAI	une				10	7	3
	uted d ansit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	ate be nysicia he bu	dlcal	•	d										/
9	ertifica ing ph e as t	Med	IF FEMALE:										-	
Box	death certifi e attending p id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	Ideath 3	Ectopic pregnancy	,			23d. Date of Month	delivery Day	Y	ear
0	0 00	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time or a	eain 5	Other (specify)							
<u>α</u>	pe pp		Part II. Other significant conditions	contributing to death b	ut not res	ulting in the u	nderlying cause giv	en in Part I.	23e. D	id tobacco	use contribut	e to the ca	use of de	eath?
rds	quires I n signe	d by							1	Yes 2	!□No 3□] Probably	4. U	nknown
Vital Records,	elaw hasb	ompleted							_ pe	itopsy erformed?	prior deat		tion of ca	
ita	i cien : Th certificate rector, pag	e	25. Was case referred to medical					26. Place	of Death (Check on		14	165 2	140	
Ž	dii b	To B	examiner?	Hospital:	ent 2 🗆	ER/Outpatier	nt 3□ DOA Oth	er: 4 □ Nur	sing Home 5 R	esidence	6 Other (5	Specify)		
n of		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Wor		28d. Descri	oe how inju	iry occurred			
sio	r Attending er death. rector: After by the fune	catl	2 Accident investigat 3 Suicide 6 Could not	he P	***			Yes 2□N		n (Ctront a	nd Alembas a	e Dural Da	uto Alum f	200
Division	l or Atten after deat Director:	ertification;	4 Homicide determine		ury - At no c. (Specif	ome, farm, str	eet, factory, office			Town, Stat	nd Number o e)	r nurai no	DIO ADITI	Jes,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in L	edical C	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	f examina	wledge, death	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and due to the control of the time.	he cause(s ne, date an	s) and manne od place, and	r as stated due to the	cause(s)	
	o the vithin i o the omple	Med	29b. Signature and title of certifier	and mainer ste			29c. Licens	e number		29d. Da	ate signed (M	lonth, Day,	Year)	
	- ≤ - ō		D. Agyall 1	Viseda V	NO		Done	2006	(MD)	121	10/04			
ì	4		30. Name and address of person who	o completed cause of d	leath (Iten	n 23a) (Type,	Print)		,	10	, - /			
	Sta	te		32. Registr	ar's Signa	iture s	(Treut	ا مح درد	-11000					
	Registr	9.7	31. Date filed (Month, Day, Year)	L 5 2004	Gregorie.		Market J							

.KD			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of			iene g. No. O L	41502
			Decedent's Name (First, Middle	, Last)				2. Date of Deat	h	3. Time of Death
	Physicia		James	Patrick	Sav	ace		DECEMBEI	R 14, 200	9:30P. M
}	/Medic Examin	or	4a. Facility Name (If not institution	, give street and number)			r Location of Deat	1	4c. County of	Death
1		•	l16 N. Eighth St	reet		OAKLAND			GARRET	Γ
	Funeral		5. Social Security Number		ge (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	. Birthplace (State or Foreign Country)
	Director		220-58-1064	153 M 2□F	53 Yrs.			Aug. 20		Maryland
	and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	laryli sho	ō		ownett		0ak.	land			1 ∑Yes 2 ☐ No
	the h	Director	10e. Street and Number	arrett		10f. Zip Code	ranu	1	0g. Citizen of Wh	at Country?
	with be or	<u>a</u>	116 N. Eighth	Street		,	21550		US	Δ
	leath	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race -	American Indian,
ပ္	within 72 hours after death with the Maryland ene. then "neturel", or llems 23e or 28e-f show the Marical Examine inset be mailfied	Funeral	1 Never Married 2 Marri	ied 1 ∰Yes 2 ☐		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puert Specify:	o Rican, etc.)		White, etc.
21215-0036	urel', c	d by	3 Widowed 4 Divorced	Year or Dates:			Specify.		Specify:	White
5	be filed within 72 ho ifal Hygiene. d other then "netui event, II. Mulical	Completed	15. Decedent (Specify only highes		(Giv	edent's Usual Occup e kind of work done	durina most of wor	rking	16b. Kind of Busin	ness/Industry
121	within ene then	dm	Elementary/Secondary (0-12)	Coilege (1-4or	5+)	DO NOT use retire				
7	be filed v fal Hygie d other t event, th		12th 17. Father's Name (First, Middle,	l ast)		Mechar		ne (First, Middle, I		Repair
Maryland		Be c			Savage		Loretta		ginia	Bergner
Ž	2 should b and Menta Is marked raumatic e	유	19a. Informant's Name/Relations			ling Address (Street			<u> </u>	
Ma	- co -	Ì	Jennifer P. Mo			3 Steyer N				
ō,	es 1 and 2 of Health a fitem 27 la r other tra		20a. Method of Disposition	on Daugneer	20b. Place of Disp	position (Name of ematory or other pla		Date	20c. Location - Ci	ty or Town, State
E S	0 0		1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S			Co. Mem. (. 1	18/04	Oakland	Maryland
Baltimore,	7 5 £ £		21. Signature of Funeral Service	1		22. Name and Addre		ewart Fu		
ä	Depar Depar Impor any ir		1 Budly	Allen	0akland	, Md. 21	550			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do not e	nter the mode of dyir	ng, such as cardia	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Stab Whow	nd To Th	e chest	-		Onset and Death
1	/Medical		resulting in death)	Due to (or as	s a consequence of):		<u> </u>		i.e	
	Examiner		Sequentially list conditions,	b						
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s а сопѕециелсе of).					
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):					
8760,	be e sician buria	<u>=</u>								
687	ficate physics the	edical		d					1	
Box	eath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Cle			23d. Date of	of delivery
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a		□Ectopic pregnanc □ Other (specify) _	y 		Month	n Day Year
P.0	fhat the de ed by the detached	hys	9 🗌 Unknown	9□ Unknown						
	res fha igned b	by F	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause gr	ren in Part I.		1.1	ute to the cause of death?
ord	w requir been si should							1 □ Ye	es 2/2/No 3	Probably 4 Unknown
Records,	elawr hasbe je 2sh	Completed						24a. Was a autops	y prio	re autopsy findings available or to completion of cause of
= E		Cou						perform 1 X Yes		ath? Yes 2□ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		0#		ath (Check only on		
of	Phys this al dii	2	1 XYes 2 No 27. Manner of Death	1 🗌 Inpat 28a. Date of Inj		ent 3 DOA	4 Nursing r		ence 6 XOther ow injury occurred	(Specify) SCENE
		lon	1 ☐ Natural 5 ☐ Pendir	ng (Month, Di		, Wo	rk? Yes 2 No			
Division	death death ctor: / the	ical	2 Accident investing 3 Suicide 6 Could	not be	njury - At home, farm,	GO:	7	28f Cocation (St	reet and Number	or Rural Route Number,
Ο̈́	after after Dire	Certification;	4 A Homicide determ	building, e	itc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Ochlord M	1, State) 1/6 N	Eighth St.
	spite nours nerel	a	29a. Certifier 1 Certifyir	ng Physician: To the bes	t of my knowledge, de	ath occurred at the ti	me, date and place	and due to the c	ause(s) and mann	er as stated.
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 X Medical	Examiner: On the basis		investigation, in my	opinion, death occi	arred at the time, d	ate and place, and	due to the cause(s)
		Σ	29b. Signature and title of certifie	r		29c. Licens				Month, Day, Year)
	AVES		Yamet BA	Ahall MD		0.0	C.M.E.	D	ECEMBER	15,2004
	34 15		30. Name and address of person	who completed cause of	death (Item 23a) (Typ		COTTO VICTORIA			
	7/14		31. Date filed (Month, Par Year)	Southall, MS	trar's Signature	111 PENN	STREET B	ALTIMORE	, MARYLAN	D 21201
	Sta Regist		DE C	T p 5004	Cora S	Good .				

	1 - State of Maryland / Department of Health and Certificate of Death	-	giene Reg. No. 00 L	41503
Physician	Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Yea	3. Time of Death
/Medica	Parley Deane Savage	Decembe	er 13, 2004	4 9:05 A. M
Examine	2017 P-16 -11 P 1	th	4c. County of De	
Funeral	2017 Reifsnider Road Keymar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	Carro	
irector	138-28-3179 Was Mark and Mark	8. Date of Birt (Month, Da Aug. 3	y, Year) , 1937	irthplace (State or Foreign Country) Maryland
show	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ing rygons and the matural; or items 23s or 28s-f show event, the Madical Examinat must be notified at Re-Commission by Financial Director	Maryland Carroll Keymar			1 ☐ Yes 2 No
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	Country?
diam is			United S	tates
Finarai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (in the control of the c	Specify Yes or No- to Rican, etc.)	- 14. Race - Am Black, Wh	nerican Indian, site, etc.
74	3 □ Widowed 4 □ Divorced If Yes, Give National 1 □ Yes 2X No Specify:		Specify:	White
Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work (If DO NOT use retired)	orking	16b. Kind of Busines	s/Industry
1	Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver		Eastalco	Aluminum Co.
ReC		me (First, Middle,	Maiden Sumame)	TITUM CO.
20		s M. Co	oddington	
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			Zip Code)
once.	Barbara Dolson Rogers Savage, wife 2017 Reifsnider	-	ymar, Mary	land 21757
	20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	r Town, State
	'4 Donation 5 Other (Specify) St. Johns Lutheran Dec.			nt, Maryland
THE PERSON NAMED IN	21. Signature of Funeral Service Licensee 22. Name and Address of Facility St.	auffer Fu	uneral Home	
1	1621 Upossumrown P			21702 Approximate
	mock, or heart failure. List only one cause on each line.	c or respiratory an	rest,	Interval Between Onset and Death
an al	disease or condition resulting in death) a			iyear
ner				
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
Examin	Cause Chiefse of Figury that initiated events resulting in death) Last Due to (or as a consequence of):			
EX	resulting in death) Last Due to (or as a consequence of):			
edicai	d			
for use as the burial-trans	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	alivery
cia	in the past 12 months? 1		Month	Day Year
Physician/M	9 ☐ Unknown			
be y	Part II. Other significant conditions continuiting to death but not resulting in the underlying cause given in Part I.		bacco use contribute t	to the cause of death?
age 2 should		12Y	es 2 No 3 P	robably 4 Unknown
Comple		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
C		perfor		s 212 No
To Be	examiner?	ath (Check only or		
100	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing		ence 6 Other (Spe	ecify)
ijo	27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 2 Accident investigation 28c. Injury at Work? 1 Yes 2 No		,,	
ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building str. (Specify)	28f. Location (S	treet and Number or R	ural Route Number,
Certification:	4 Homicide building, etc. (Specify)	City or Town	n, State)	
edical (29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only of the place).	a, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated.
Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number		9d. Date signed (Mon	
_	1 / D / 1 8 / 1 8 /	66 0	Perm hos	13.2004
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	E CEVILVEI	10/20-1
	Kanan Hudhud, MD 46B Thomas Tehngon Dr.	+ cont	erick M	13,2004
State	31. Date filed (Month, Day, Year) 32. Register's Signature	, , , , , ,		, , , , ,
istrar	DEC 19 7004			
Rev 1/2001				
	ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. CU 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** SYLVESTER J. THOMAS SR. DECEMBER 8 2004 8:35 PM M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Seat Pleasant 109 68th Place Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1<u>₩</u>M 2□F Yrs 579-10-4682 86 Director October 12 1918 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show rat', or items 23a or 28a-f shov Examinar must be notified at 1 ¥Yes 2 □ No Seat Pleasant Director Prince George's MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 20743 109 68th Place Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ★Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: **Black** 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 2 should be filed and and Mental Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th Private Supervisor other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0livia Spriggs Thomas Robert P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 68th Place Seat Pleasant, Maryland 20743 Tina Marie Thomas/Daughter itam 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 12/15/04 Suitland, Maryland 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home B 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Prostate Cancer Physician** resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) death certificate be executed Exam ician and burial-trans Due to (or as a consequence of): physician Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown signed by the The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? has page certificate 1 Yes 2**C** No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Be Other: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After Certification: Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident in by the Diractor 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide To the Hospital hours To tha Funarai 🔼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12-10-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Hajjar M.D. 4850 Forbes Blvd Lanham, Maryland 20706 31. Date filed (Month, Day, Year) . Registrar's Signature State DEC 1 6 2004

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

			1 - For State Registrar	State of Mar		artment of H			giene Reg. No. 2	14 4150	
*	Physic /Medi	cal	Decedent's Name (First, Middle, Last Aa. Facility Name (If not institution, give	Edna L.	Tonigan	4b City Town o	r Location of Death		Day 15, 20		
	Examir Funeral	ier	15814 Erwin Cour 5. Social Security Number 6. Se	7. Age (In yrs. last birthday)	Bowie If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	Prince	e Georges Birthplace (State or Foreign Country)	
L	Director		343-05-6166 Usual Residence of Decedent 10a. State 10b. County		91 Yrs. Oc. City, Town or Lo			Nov. 6		Illinois 10d. Inside City Limits	
	be filed within 72 hours after death with the Maryland nat hygiene. od other than "natural", or Items 23a or 28a-1 show event. I've Mexical Evarring must be notified at	Funeral Director	Md. Prince Go 10e. Street and Number 15814 Erwin Court 11. Marital Status 1 Never Married 2 Married		Bowie	10f. Zip Code 2071 Was Decedent of H	6 lispanic Origin? (Span, Mexican, Puerto		USA 14. Race - Black,	at Country? American Indian, White, etc.	
Baltimore, Maryland 21215-0036	filed within 72 hours af Hygiene. rther than "natural", or sht, I'ss Medical Evarn	Completed by F	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	If Yes, Give 12 Year or Dates:	16a. Dece (Give life.			king	Specify:	ŕ	
yiang z	should be filed and Mental Hygis marked other umatic event.	To Be Co		Buckalew		omemaker	Susa	n Buckal			
юге, маг	ss 1 and 2 of Health a Item 27 is other trai		19a. Informant's Name/Relationship (T) William E. Tonigan 20a. Method of Disposition 1 □ Burial 2 反 Cremation 3 □ F	n - Son	15814 20b. Place of Dispo cemetery, crer	Erwin Co sition (Name of natory or other place	^(e) 12-1	rie, Md. Date 5-04	20716 20c. Location - Ci	ty or Town, State	
Daint	permit Pege Department (Important: If any injury or once.		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Metropolitan Crematory 22. Name and Address of Facility 22. Name and Address of Facility 6512 N.W. Crain Hwy., Bowie, Md. 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								
	Physician /Medical Examiner	liner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury)	ne cause on each line. a. <u>Cerebr</u>	onsequence of): Fibrill	accide		or respiratory arr	est,	Approximate Interval Between Onset and Death Lucek Lucek	
DOX 00/00,	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical Examine	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a cd. 23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at time)	pregnancy Fetal death 3	Ectopic pregnancy			23d. Date of Month	,	
S, T.C.	requires that the di een signed by the hould be detached	by Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions con	9□ Unknown			en in Part I.	23e. Did to	bacco use contribu	Ite to the cause of death?	
חומספעו וו	The law ate has b page 2 sl	Completed	Hypentension	disease				1 Ye 24a. Was a autops perforr	in 24b. Wei	Probably 4 Unknown re autopsy findings available r to completion of cause of th? Yes 2 No	
חואואוטוו טו אוואו הפכטום	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes No	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injun Worl	26. Place of Deat er: 4 □ Nursing Ho / at Yes 2 □ No</td <td>ome X Reside</td> <td>ence 6 Other ow injury occurred</td> <td>(Specify)</td>	ome X Reside	ence 6 Other ow injury occurred	(Specify)	
באַמ	를 갖 # c	Il Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (Specify)			City or Towr	n, State)	or Rural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29b. Signature and title of certifier	sician: To the best of mer: On the basis of ex and manner stated	amination and/or inv	restigation, in my op	oinion, death occur	red at the time, d	ause(s) and manner ate and place, and 9d. Date signed (A	due to the cause(s) Month, Day, Year)	
-(2)		30. Name and address of person who co	empleted cause of deat	h (Item 23a) (Type,	Print) W	Villiam /	. Hammer			
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 6 2004	Registrar's	Signature	W					

			1 - For Stata Registrar	State of Maryland		artment of H tificate of L			giene Reg. No:		41506
	Physici /Medic			FORIELLO				2. Date of De Month DECEME	Day	16 20	3. Time of Death 04 6:45p M
}	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or		eath	4c.	County of Dea	th
			Corsica Hills 5. Social Security Number 6. Security		st hirthday)	Centre		Irs. 8. Date of Bir			Anne's thplace (State or Foreign
	Funeral Director			JM 2□F 85	Yrs.	Months Days		July 1	2 ,	1919 1	New Jersey
	Maryland f ehow	tor	10a. State 10b. County MD Kent		Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e	irec	10e. Street and Number	, ,,	1 0011	10f. Zip Code			10g. Citi:	zen of What Co	ountry?
	th with	ai D	12613 Walnut V	alley Court		21678			U.	S.A.	
920	72 hours after death with the Maryland natural', or itams 23a or 28e-1 ehow disal Examinat pust be multised at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: WWII			spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)		14. Race - Ame Black, Whit Specify: V	
21215-0036	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. L	tent's Usual Occupa kind of work done of DO NOT use retired r - Ope	luring most of v	working	Fu	el Oil	
d 2	filed Hygid Sther	e Co	17. Father's Name (First, Middle, Last)	4	Owne	I - Ope		Name (First, Middle,			marcioning
Maryland	2 should be and Mental le marked or raumatic ever	To Be	Alphonse Torie					ualina D			
Mar	nd 2 sh alth and 27 le m r traum		19a. Informant's Name/Relationship (Ty Anne P. Toriel			g Address (Street a 3 Walnu		Rurai Route Numbe		rton, State, .	
Baltimore,	Pages 1 and 2 nent of Health int: If Itam 27 iry or other tra		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ R	ra.	ace of Dispo metery, cren	sition (Name of natory or other place	9)	Date	20c. Lo	cation - City or	Town, State
Ē	rtmen rtant: njury		' 4 □ Dopation 5 □ Other (Specify) 21. Signature of Fone(at Service Loss)					2/20/04			
Ba	permit. Page Department of Important: If any injury or		1-100	моо5	10 11	8 West	Cross	St. Gal	ena	ephen, MD.	L Schaech 21635
	Pnysician /Medical Examiner		Sa Party Enter the disease, or complished shock, or heart failure. List only or immediate Cause (Fhal disease or condition resulting in death)	ications that caused the death. ne cause on each line. a	Do not ente	92.0	g, such as card	5	rest,		Approximate Interval Between Onset and Death
8760,	rate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last								
.O. Box 68	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3□	Ectopic pregnancy Other (specify)			2	3d. Date of del	ivery Day Year
rds, P.	es gn be	by	Part II. Other significant conditions cor	ntributing to death but not resul	ting in the ur	nderlying cause give	n in Part I.	23e. Did to	_	se contribute to	the cause of death?
Vital Record	The law ate has b page 2 sl	Completed						24a. Was autop perfor 1 □ Yes	sy	prior to death?	itopsy findings available completion of cause of 2 No
Ž	Physiclen: this certific ral director,	Be c	25. Was case referred to medical examiner?	lospital:		Othe		Death (Check only o			
of	ding Phys h. After this funeral di	tion; To	27. Magner of Death 1 Natural 5 Pending	1 □ Inpatient 2 □ E	R/Outpatien 28b. Time of Injury	28c. Injury Work	at	g Home 5 Resid			oify)
Division	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After thi completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre			28f. Location (S City or Tow		Number or Ru	ıral Route Number,
	e Hospital 124 hours a e Funaral letely filled	edical C	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim restigation, in my op	e, date and pla inion, death oc	ace, and due to the occurred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and file of certifier			29c. License			29d. Date	signed (Monti	h, Day, Year)
•			// //////////////////////////////////				3703	L		7/17/	2004
			30. Name and address of person who co				Oh	tor MD	2.1	610	
	Sta		Gary Sprouse 31. Date filed (Month, Day, Year)	32. Fe gistrar's Signatu	re .	nato Dr	• Cnes	ter, MD	• 4.	019	
	Registr	ar	DEC 1 7 20	04 Degree A	July All						

			1 - For State Registrar	State of Marylan	d / Depa		lealth and I	Mental Hygi	ene a. No. 2001	1.1507		
Ī	Physici	an	1. Decedent's Name (First, Middle, Last) Judith	М.				2. Date of Death Month	Day Year	3. Time of Death 22:52 M		
	/Medic		4a. Facility Name (If not institution, give st			Thompso	r Localion of Dealt	December	4c. County of Dea			
	Examin	er	401 Pamela Drive	eet and traineer)		Salisbu			Wicomico	uii		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth				
l,	Director		074-20-6232 ¹□ Usual Residence of Decedent	^{M 2} √2 F 78	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 11/5/19	26 Mas	ssachusetts		
	yland		10a. State 10b. County	10c. Cit	y, Town or La	cation				10d. Inside City Limits		
	Mar 6-fel	cto	Maryland Wicomico	5	Salisbu	ıry				1 ☐ Yes 2 No		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ttems 23a or 28e-f ehow any injury or other traumatic event, Ite Mudical Exacilities and be notified at once.	Funeral Director	10e. Street and Number 401 Pamela Drive			10f. Zip Code 2180	4	10	g. Citizen of What C	ountry?		
	deat	ner	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Am			
920	urs after al', or ite	by Fu	1 Never Married 2 Married 3X Widowed 4 Divorced	1 Yes 2X No If Yes, Give Year or Dates:			Specify:	o riicari, etc.)	Black, Whi	white		
15-0	iin 72 ho n "natur Audical	Completed by	15. Decedent's Educi (Specify only highest grade	completed)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor d)	king 1	6b. Kind of Business	Andustry		
212	filed withi Hygiene. other than ent, Ire M	mo	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Home	emaker			Domestic	C		
Maryland 21215-0036	2 should be filed and Mental Hygid is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Harold L. Cox					me (First, Middle, Maiden Sumame) en D. Wagner				
ary	shou ind M imar	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State,	Zip Code)		
	1 and 2 Health a tem 27 is		George W. Thompson	/son	906	Friar Tu	ck Lane,	Salisbury	, MD 21804	4		
ore,	es 1 a of He riterr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	ce)		Oc. Location - City or	Town, Slate		
<u><u>Ĕ</u></u>	Pages ment of I ant: If its ury or o		1 Nation 2 □ Cremation 3 □ Rel	Mic	comico	Memorial	Park 12	2/18/04	Salisbury	, MD		
Baltimore,	permit. Pages Department of Important: If it any injury or o									Association		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deat						Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	, oddoo o'i oddi iiio.	AS	avi				Onset and Death		
7	/Medical		resulting in death)	Due to (or as a conseq	uence of):	_0,)						
	Examiner		Sequentially list conditions. b.									
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseq	uence of):							
	ate be executed hysician and the burial-transit	Examiner	that initiated events c. resulling in death) Last	Due to (or as a conseq	uence of):							
,160,	be egician buria	icalE										
687	ficate physis the		d.									
. Box	that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Med	in the past 12 months?	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnancy Other (specify)	/	·	23d. Date of de Month	livery Day Year		
P.0	d by t	Phy	9 ☐ Unknown Part II. Other significant conditions cont	shuting to dooth but not soo	ulting in the	adashina asuga siy	en in Boot i	230 Did John	ucco uco contributo l	o the cause of death?		
ords,	The law requires that the ate has been signed by th page 2 should be detache	ed by	Parti. Ottor significant conditions cont	induting to death but not les	aiting in the di	ndenying cause giv	en in ran i.			robably 4 Unknown		
Record	e law re has be je 2 sho	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of		
H		Som						perform	ed? death? 1 No 1 ☐ Yes			
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			ii.		th (Check only one)			
of \	Physicien: this certific ral director,	P	19 105 2010	spital: 1 Inpatient 2			+ Cartaining in		ce 6 ☐Other (Spe	ocify)		
		ion:	27. Manner of Death 1 Natural 5 Pending	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe how	injury occurred			
Sic	Vttendii death. ctor: Ai y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Bloos of laiver. At he	ama form sta		Yes 2 ☐ No	29f Location /Stre	et and Number or R	ura I Pauta Number		
Division	l or Attencater death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	eet, ractory, office		City or Town,		urai noule ivumber,		
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical Co	(Check only 2 Medical Examin)	cian: To the best of my kno On the basis of examina	wledge, death	n occurred at the tin	ne, date and place pinion, death occu	, and due to the cau	use(s) and manner as e and place, and due	s stated. e to the cause(s)		
	the hin 2 the mplet	Med	onej	and manner stated.		29c. Licens			d. Date signed (Mont			
_	To To		29b. Signature and title of certifier	L. Che		250. LICENS	50497	29	12 14 04	, 567, 1501/		
	,n ,		7				3 - (/					
	(VIII)		30. Name and address of person who con			•	14 -1	MD 04.004				
	Sta	te.	Dr. Chris Snyder 31. Date filed (Month, Day, Year)	32. Reafstrar's Signa	arroll	St., Sal		MD 21801				
	Regist		DEC 1 5 20	14 Deserva		Space	N					

		partment of Health and Men e <i>rtificate of Death</i>	tal Hygiene
Physician /Medical	Decedent's Name (First, Middle, Last) THOMAS PARKER TOPPING	1	Date of Death Month Day Year PCCEMber 14, 2004 131 A Time of Death M
Examiner	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthda)	4b. City, Town, or Location of Death Berlin	4c. County of Death Worcester
Funeral Director	5. Social Security Number 6. Sex 1 9 7. Age (In yrs. last birthda 1 9 7 9 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	Months Days Hours Min. (1	pate of Birth Month, Day, Year) Irch 10,1950 9. Birthplace (State or Foreign Country) MD
Marylan a-f ehow illied at	MD Worcester Snow Hi		10d. Inside City Limits 1 ☐ Yes 2 ▼No
Salter death with the Maryland streng 23a or 28a-f show christ the notified at the result the notified at Funeral Director	10e. Street and Number 6740 Cedartown Rd.	10f. Zip Code 21863	10g. Citizen of What Country?
5 2 3 5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: Vietnam	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	
Maryland 21215-0036 d 2 should be filed within 72 hours after. Ith and Mental Hygiene. 77 is marked other than "natural", or ite traumatic event, its Medical Examires To Be Completed by Fur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menal at Hygens. Inportant; If item 27 is marked other than "naturany injury or other traumatic event, If a Michael and sinjury or other traumatic event, If a Michael and any injury or other traumatic event, If a Michael and any injury or other traumatic event, If a Michael and any injury or other traumatic event, If a Michael and any injury or other traumatic event, If a Michael and a Michael and I injury or other traumatic event, I in the second event event in the second event	17. Father's Name (First, Middle, Last) Robert Eugene Topping		Poultry st, Middle, Maiden Sumame) raine Dean
h and Men 7 is marke fraumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Rou	
ages 1 and of Healt to f Healt to the titem 2:	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, cre	ematory or other place)	and a second of the second of
Departme importan any injuri once	'4 □ Donation 5 □ Other (Specify)	nlopen Crem. 12-15-04 22. Name and Address of Facility The 108 William St., Berli	Burbage Funeral Home
Fnysician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	nter the mode of dying, such as cardiac or resp	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):		
ad by the attending ph detached for use as th Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
been signed I should be det	Part II. Other significant conditions contributing to death but not resulting in the the significant conditions contributing to death but not resulting in the time.		3e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
is certificate has been s director, page 2 should o Be Completed	WAS AWAITING LINER TRIAM		4a. Was an autopsy autopsy findings available prior to completion of cause of death? Yes ★○No 1 ☐ Yes 2 ☐ No
Physician this certifi al director To Be	25. Was case referred to medical examiner? 1 □ X ves 2 □ No Hospital: 1 □ Inpatient 2 ▼ER/Outpatie	26. Place of Death (Chemint 3 DOA Other: 4 Nursing Home 5	ck only one) □ Residence 6 □Other (Specify)
rs effect death. al Director. Affect led in by the funers Certification:	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 6 Could not be determined determined	of 28c. Injury at 28d. D Work? M 1 ☐ Yes 2 ☐ No	escribe how injury occurred
hours efter meral Direct y filled in by	29a. Certifier 1 Certifying Physician: To the best of my knowledge deat	Ci	cation (Street and Number or Rural Route Number, ty or Town, State)
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Medical Certification; To Be Completed by Physician/Med	29b. Signature and title of certifier	vestigation, in my opinion, death occurred at the 29c. License number	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (Type,	D06241	12-15-04
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	03 Snow St., Snow H	ill, Md. 21863
HMH 17 Rev 1/2001	Supplied by		

			epartment of Health and Me Certificate of Death		.n2004 41509
Physic		Decedent's Name (First, Middle, Last) SHIRLEY ANN	THOMAS	2. Date of Death Month	Day Year 3. Time of Death
/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	DEC. 13	2004 1:20 P M
*		CARROLL HOSPITAL CENTER	WESTMINSTER		CARROLL
uneral rector		5. Social Security Number 177-26-1260 Usual Residence of Decedent	nday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. C	3. Date of Birth (Month, Day, Ye 0 / 10 / 19	ear) 9. Birthplace (State or Foreign Country) PENNSYLVANIA
ir featin and Mental Hygene. item 27 le marked other then "naturel", or items 23a or 28e-f ehow other treumatic event, the Medical Examinat must be collined at	_	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
offfice.	Director	MD • CARROLL WES	TMINSTER		1 □Yes 2X No
H Dear	Dir	414 LEPPO RD.	10f. Zip Code 21158	10g.	. Citizen of What Country? USA
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	14. Race - American Indian, Black, White, etc.
	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ANo Specify:	, - ,	Specify: WHITE
	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	161	b. Kind of Business/Industry
	фшо	Elementary/Secondary (0-12) College (1-4or 5+)	HOUSEWIFE	н	OME MAKER
	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Mai	den Sumame)
	Jo	JOHN VAN AUKEN 19a. Informant's Name/Relationship (Type, Print) 19b.	RACH		RRIES
eny injury or other treumatic event, ing medical Examinat must b once.			Mailing Address <i>(Street and Number or Rural F</i>		
5		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State 1 ☑ Donation 5 □ Other (Specify)	Disposition (Name of place) DE CEMETERY 12/16	e 200 /2004 т	Location - City or Town, State
once.		21. Signature of Funeral Service License	22. Name and Address of Facility ${ m FLE}$	TCHER F	UNERAL HOME
8 G		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heardfailure. List only one cause on each line.	254 E. MAIN ST., V	WESTMIN	STER, MD. 21157 Approximate
ician		shock, or heardfailure. List only one cause on each line. Immediate Cause (Final disease or condition	ou of COPI		Onset and Death
dical iner		resulting in death) a. Due to (or as a consequence of):		Zmonths
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burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
	ā	resulting in death) Last Due to (or as a consequence of d.):		
for use as the	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		-	
detached for L	Physician/Medic	23b. Was decedent pregnant in the past 12 moortis? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	<u> </u>	23d. Date of delivery Month Day Year
pe deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
				1 PYes	2 No 3 Probably 4 Unknown
a special constant	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
	e e	25. Was case referred to medical	26. Place of Death (0	1 ☐ Yes 2 🗹	No 1 ☐ Yes 2 ☐ No
1	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Out;	04		6 □Other (Specify)
	tion:		ne of 28c. Injury at 28c work? M 1	l. Describe how in	njury occurred
completely med in by me	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fame building, etc. (Specify)		Location (Street City or Town, St	and Number or Rural Route Number, ate)
	OI	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and	I due to the cause	o(s) and manner as stated.
	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated. 29b. Signature and title of certifier	or investigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
	_	29b. Signature and titre of cantiler	29c. License number 1.0 0 3 47 9 8		2-14-7.004
		30. Name and address of person who completed cause of death (Item 23a) (T	(Pa. Print)	2 (1	2-14-2004 lest minster, MD 2115
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	10/11 ISTUR SE	- u	restminster, MD 2115,
gistr		DEC 1 4 2004 Server &	Sperk		
7 Rev 1/20	JU I	ORIG	INAL		

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Inompsin Month Year ward 10101 PM /Medical 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Maryland Bultimore Medical 5. Social Security Number If Under 24 Hrs. 6. Sex If Under 1 Year **Funeral** 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) 9. Birthplace (State or Foreign 1**∑**M 2□F Days Hours Director 228-30-3682 75 NEW YORK 14, 1929 Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f ahow 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director DE SUSSEX 1 ☐ Yes 2 No SELBYVILLE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Itams 23a 60 EAST STONEY RUN 19975 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No 1951—
If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) CONSTRUCTION/ College (1-4or 5+) 12 OWNER/OPERATOR REMODELING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 EDWARD A. THOMPSON RENA REID 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra IVA ELLEN THOMPSON/WIFE 60 EAST STONEY RUN, SELBYVILLE, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY | 12/16/2004 STEVENSVILLE, MD 21. Signature of Feneral Service Licensee: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rofound disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death Year 5 Other (specify) the i 9 Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, plnods 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed certificate 2 No or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funerat Director: After th completely filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending death. 1 □Yes 2 □No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the Funerat [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

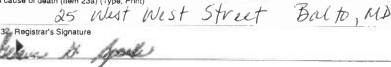
State Registrar DHMH 17 Rev 1/2001

Kristian

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MD

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		1 - For State Registrar	State of Marylan	d / Depa	artme		ealth and	Mental Hyg	`	004	4151
		Decedent's Name (First, Middle, Last)					2. Date of Deat	h	Year	3. Time of Death
Physic /Medi		Irene El		ıs				December		2004 2004	7:20 a.
Exami	ner	4a. Facility Name (If not institution, give					Location of Deat			nty of Death	
		Vindobona Nursir 5. Social Security Number 6. Se		last hirthday		er 1 Year	k Height			ederic	
Funeral Director			м 287 г 89	Yrs.		Days	Hours Min.		Year)	Mar	place (State or Fore ntry) yland
within 72 hours atter death with the Maryland ene. Than "neturel", or Items 23a or 28a-f ahow he Madigal Exement must be nyttied at	_	10a. State 10b. County		y, Town or Lo							10d. Inside City Limi
28a-f	Director	Maryland Frederi 10e. Street and Number	.ck My	ersvil		ip Code		1.	0g. Citizen o	of Mart Cour	
3a or	I Dir	11011 Easterday Ro	ad			21773		,	og. Ottizeri (USA	iiu y i
ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dec	edent of His	panic Origin? (S	pecify Yes or No- o Rican, etc.)		lace - Amen	
Francis	1 by Fu	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		_	2 ∑ No	Specify:		Spec		nite
iene. rthan "naturel", or Items 23a or 28a-f ahow Itte Medical Examinar must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give	kind of	ual Occupa vork done di use retired)	tion uring most of wo	rking	16b. Kind of	Business/In	ndustry
I Hygiene. other than ent, the M	Con	7		Hor	nemal				Own 1		
D O	Be	17. Father's Name (First, Middle, Last)	To					ne (First, Middle, I		ame)	
	ို		loup					ısan Gre			
7 Is		19a. Informant's Name/Relationship (7) Elsie Warnock / co		1	-			_{iral Route Number} iddletown			
E E		20a. Method of Disposition		Place of Dispo	sition (N	ame of			20c. Location		
nent of ant: If its ary or o		1 □XBurial 2 □ Cremation 3 □ F '4 □ Donatiop 5 □ Other (Specify)	temoval from State	Zion l				16-04 M	yersv	ille,	Maryland
Department of the first or of any injury or of once.		21. Signatury of F. Heral Service Licens	hite			and Address	of Facility uneral H		Main rsvill		t 21773
hysician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	fications that caused the deat ne cause on each line.			, -			est,		Approximate Interval Between Obset and Death
ath certificate be executed by attending physicien and for use as the burial-transit of	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence do consequence Due to (or as a consequence do consequen								
y the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3	Ectopic Other (pregnancy specify)				Date of deliver	ery Day Year
signed t	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying	cause giver	n in Part I.	23e. Did tob	1.		he cause of death? pably 4 □Unknov
cate has been signed by	Completed							24a. Was an autops perform	v	o. Were auto prior to co death? 1 \(\text{Yes}	psy findings availab impletion of cause o
this certific	Be	25. Was case referred to medical examiner?	Hospital:					th Check only one	-		
this (2	1 Yes 2 No	1 Inpatient 2	ER/Outpatier 28b. Time o			4 Nursing H	ome 5 Reside			y)
after death. I Director: After t	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	Injury	М		es 2 No	28d. Describe ho			
4 hours after of Funerel Directed Funerel Directed Filled in by	Certif	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)				28f. Location (Str City or Town	, State)		
within 24 hours after of the Funerel Directompletely filled in by	edicai	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurre vestigation	d at the time on, in my opi	e, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and rate and place	manner as s e, and due to	tated. o the cause(s)
within 2 To the complet	Me	29b. Signature and title of certified	Rain MD		2	9c. License	number 16675	29	d. Date sign		Dey, Year)
)		30. Name and address of person who co	omplited cause of death (Item	_		inth A	Ave., Br	unswick,	MD 21	716	
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa		A	antile s					-

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_			1 - For Stete Registrer	State of Maryland		rtment of h			iene _{19. No.} 2004	41512
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Ethel 4a. Facility Name (If not institution,	Williams	5	4b. City, Town, o	or Location of Dea	2. Date of Death Month December	Day Year	3. Time of Death 11:30 P M
	Funeral Director	H	241-52-6956	Genesis 3.Sex 7. Age (In yrs. Ia. 1□M 2気F 67	st birthday) Yrs.	Silver S If Under 1 Year Months Days		(Month, Day	Montgomer Year) 9. Bir 7 1937 No	ry thplace (State or Foreign puntry) orth Carolina
Baltimore, Maryland 21215-0036	ifficial waryland Pages 1 and 2 should be fill nent of Health and Mental H nut: If item 27 Is marked oth		Usual Residence of Decedent 10a. State 10b. County MD Montgo 10e. Street and Number 19114 Pear Tree 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Li James G. Whitfi 19a. Informant's Name/Relationshi George Williams 20a. Method of Disposition 1 Burial 2 Cremation	Dimery Si Lane # 14 12. Was Decedent Ever in U.S. Armed Forces? 1	113. V 116a. Deced (Give life. L Chil	Spring 104. Zip Code 20906 Vas Decedent of F Yes, specify Cub. Yes 22 No ent's Usual Occupind of work done O NOT use retired d Care g Address (Street Pear Tr	Specify: pation during most of wood) 18. Mother's Natie Ratie and Number or R ee Ln #	Specify Yes or Norto Rican, etc.) orking me (First, Middle, M Bellamy ural Route Number, 14 Silver Date 2	og. Citizen of What Co. S.A. 14. Race - Ame Black, White Specify: 6b. Kind of Business. Private aiden Sumame) City or Town, State, 2 Spring, No. Location - City or	10d. Inside City Limits 11 Yes 2 □ No puntry? Indian, e, etc. Black Industry Indu
Baftim	permit. Pa Departmen Importent: any injury		*4 □ Donation 5 □ Other (Spe 21. Signature of Eumeral Service Li	proplications that caused the death.	7.4	74 Lando	ss of Facility J.	.B. Jenkir Landover		
Box 68760,	death certificate be executed by Medical Example and for use as the burial-transit	ian/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequent b. Diabe Due to (or as a consequent c. Hyper Due to (or as a consequent d. Sepsi	etes Monce of): ctensi nce of): is	on Ectopic pregnancy			23d. Date of deli	
О	ires that the signed by th d be detache	ed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown s contributing to death but not resulting		Other (specify)	en in Part I.		Month cco use contribute to 2 \(\text{No} \) 3 \(\text{Pro} \)	the cause of death?
Vital Records,	The ate h page	e Completed	25. Was case referred to medical				26 Place of Dec	24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of 2 No
IVISION OF	or Attending Phys fter death. irector: After this n by the funeral dii	Certification; To B	examiner? 1 Yes 2 No 27. Manuar 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	28a. Date of Injury (Month, Day Year)	VOutpatient Bb. Time of Injury e, farm, street	28c. Injury Work M 1 🗆	er: 4 🖾 Nursing H	lome 5 Residence 28d. Describe how	et and Number or Rui	
2	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the best of my knowle aminer: On the basis of examination and manner stated.	edge, death and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	and due to the cause	co(c) and manner as	stated. to the cause(s)
R	To II withi	W		o completed cause of death (Item 23		,	56691	l	Date signed (Month)	4
	Sta Registr	-30	Gnousia Sultana 31. Date filed (Month, Day, Year) DEC 1 6 200	M.D. 12107 Herit	9 🚜		ere, Silv	ver Spring	, Maryland	1 20906

			For Stete Registrar	State o	f Marylan	•	artmen				/lental Hy	00	04	41513
			Decedent's Name (First, Middle, La	st)							2. Date of Dea		Vone	3. Time of Death
	Physici /Medic		Anna L. Wil	liams							Decembe	r 12 2	2004	11:31 A ^M
	Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of	of Death		4c. Count	y of Death	
			Ft. Washington	Hospita	1			F			ngton	Pri	ince	George's
	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	(Month, Da	v. Year)	9. Birth	place (State or Foreign ntry)
	Director		311-30-0132A		93	Yrs.					June 19	, 1911	Wa	sh., DC
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	f sho	៰	Maryland Prince	George'		17	7+ T.T.						1	1 X Yes 2 ☐ No
	the 1	rect	10e. Street and Number	George	5		It. Wa		ngton		<u> </u>	10g. Citizen of	What Cou	ntry?
	3a or	0	12811 Pine	Tree La	ine				207	44				States
	death with the Maryland ms 23a or 28e-f show	Funeral Directo	11. Marital Status	12. Was Dece	edent Ever in U.	.S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	pecify Yes or No- Rican, etc.)		ce - Ameri	can Indian,
9	or Ite	Ē	1 Never Married 2 Married	1 ☐ Yes	edent Ever in U. rces? 2 XNo	1	fYes,spec 1 □ Yes 2			1, Puerto	Hican, etc.)		ck, White	
21215-0036	72 hours after death with the Marylan "natural", or items 23a or 28e-f show officel Examilier must be indiffed at	d by	3 X Widowed 4 ☐ Divorced	Year or Da	ates:		TU Tes a	Z LAL INO	Specify:			Specia	ту: В	lack
5-	"natural",	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation furing mos	t of work	king	16b. Kind of B	Bu <i>s</i> iness/Ir	ndustry
121	C _ 38	mpl	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. i								
7	Hygie Tygie ther t	ပိ	12th 17. Father's Name (First, Middle, Last)			1	Rive		ar's Nam	e (First, Middle,			t - Navy
anc	ntat led of	Be o	William		IS.				TO. INICITIC	Ji S I Valin		Washin		
Maryland	12 should be filed within " h and Mental Hygiene." 7 Is marked other than " treumatic svent, I're Mod	၉	19a. Informant's Name/Relationship (19b. Mailir	a Address	(Street a	and Numbe	er or Rui	ral Route Numbe			n Code)
\geq	ges 1 and 2 should be filed within to f Health and Mentat Hygiene. If item 27 Is marked other than or other treumatic svent, Item Meres		Joseph M. Belge		- Son	1					ofton, M			
ē,	of Health of Health item 27 I		20a. Method of Disposition	EL DIO	20b. P	Place of Dispo	sition (Nan	ne of	-	Orc	Date Date	20c. Location		
9	7 1 2 2		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		State	-	-			12/1	8/2004	Suit1	and.	MD
Ħ	21 Signal we of Tuneral Service Licenses 22 Name and Address of Facility Stewart													
m	Department		low T.	Deleso	W 11	1	4001	l Ber	nning	Rd.	, N.E.	Wash.,	DC 20	0019
	•		23a. Part1. Enter the disease, or com	ia. Part I finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										Approximate Interval Between
	Physician ∶		Immediate Cause (Final disease or condition		CHEY	MIC	C	S	TIE	5				Onset and Death
	/Medical		resulting in death)	W1	or as a consequ									
	Examiner													
	p is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	72-31 194-63	F100	0 -						
	and -trans	Kam	that initiated events resulting in death) Last	c. Due to	or as a consequ		1001	140						
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	ate hy:	Physician/Medical	2-3-2	_ d										·
9 x	eath certific attending pl	//We	IF FEMALE:	23c. If yes, out	come of pregna	incy						23d Da	ate of deliv	env
Вох		clar	23b. Was decedent pregnant in the past 12 months?		inth 2 Fetal		Ectopic pro						onth	Day Year
0	that the death ed by the atte detached for	lysl	1 Yes 2 No 9 Unknown	9□ Unkno	own			77						
۳,	requires that the een signed by th nould be detache	by PI	Part II. Other significant conditions	contributing to de	eath but not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use con	tribute to t	he cause of death?
rg	w requires that been signed to should be det	be b					_				1 🗆 Y	es 2□No	3 🗌 Prol	pably 4 □Unknown
	24a. Was an 24th autopsy								Were auto	ppsy findings available				
Ä	0 = 0	24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? Hospital: 4. Other							med?	death?	impletion of cause of 2 No			
ita	ien: ntifica ctor, p								21					
5	di S	्र च व 1 Li Yes 2 L f No 1 Li Inpatient 2 Li ER/Outpatient 3 Li DOA 4 Li Nursing Home 5 Li Residence 6								ence 6 🗆 Oth	ner (Specia	(y)		
ם	ng P									28d. Describe h	ow injury occur	red		
si.	2 Accident and Suicide 6 Could not be 380 Place of Injury. At home form starts feature of the same form													
Division	or At	ill.	4 Homicide determined	289. Place	of Injury - At ho ng, etc. (Specify	ome, farm, str v)	eet, factory	, office			City or Tow		ber or Rura	al Route Number,
	pitel ours a erel I		29a. Certifier 1 💢 Certifying Pl	veicien: To the	hact of my know	wlodge doeth	. annumad .	at the tim	o data an	d alaaa	and due to the			A-A- d
	Hos 24 hc Fun etely	edical	(Check only 2 Medicel Exer	miner: On the ba	asis of examinat	tion and/or in	estigation,	in my op	e, date an pinion, dea	d place, th occur	and due to the d red at the time, d	ause(s) and ma date and place,	anner as s and due t	tated. the cause(s)
	ithin o the	Me	29b. Signature and title of certifier				29c	. License	number		- 2	29d. Date signe	ed (Month,	Day, Year)
	- 3 - 0		Many	10 me 24	140		1	14	215	8	T	DEC 17	,	2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)														
4			692 OXON HIL	L NOK				3	HTL	L	MD	207	45	
	Sta	te	31. Date filed (Month. Dav. Year)	B. R	egistrar's Signa		L.	-						
	Registr	ar	DEC 1 6 200	4 000	we so	Maria								

04-06608-033 Shirley Wiley RJD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 72, 2004 2151P. Shirley Wiley /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges Examiner Prince Georges Hospital Center Cheverly 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 Months Days Hours Min. Director 579-76-8547 July 23, 1953 Wash. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 □ No Directo Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 7329 Marlboro Pike #12 20747 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after used Mental Hygiene.
Is marked other than "natural", or Iter 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Maintenance Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pace Jame Alice Gladden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an 4261 Brooks St., N.E. Wash., DC Katrina Wiley - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury of once. Lee's Crematory 12/16/2004 Clinton, MD 21. Sig ature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC levous 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediaty Cause (Final disease or condition Physician Ovarian carcinoma with metastat resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): physician s the burial Records, P.O. Box 68760 Physician/Medical as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 □ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 2 1 √ Yes 2 □ No After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
25 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) October 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

DEC 1 6 2004 Registrar's Signature -

			For State Registrar	State of Marylan	d / Depa				ne	41515
	Physic	ian	Decedent's Name (First, Middle Monsia		1.7 - 1.1			2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Marie	Strange	Wall			ecember 1	5, 2004	10:00 A ^M
	Examir	ner	4a. Facility Name (If not institution	_	D - L - L		or Location of Death		4c. County of Death	
			5. Social Security Number	eview Nursing & F		Clinton If Under 1 Year		8. Date of Birth	rince Geo	
	Director		230-01-7369 Usual Residence of Decedent	1□ M XXX 92	Yrs.	Months Days		09/08/191	2 Vi	place (State or Foreign intry) rginia
	e Maryland le-f show	ctor	10a. State 10b. County Maryland Prince		y, Town or Lo amp Spi					10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th	ral Dire	10e. Street and Number 6102 Carswell 7	Terrace		10f. Zip Code 20746	ó	10g.	Citizen of What Cou USA	ntry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23c or 28e-1 show other treumetic event, the Medical Exams at must be multiple at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri ॲ॔॔॔॔ऑodowed 4 ☐ Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 □ Yes ②13 No If Yes, Give Year or Dates:	J:	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W]	
21215-0036	within 72 ho ene. then "natur he Medical	ompleted	15. Decedent (Specify only highes Elementary/Secondary (0-12) 1.2	t's Education st grade completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire nemaker	pation during most of working d)	ng 16b	Kind of Business/Ir	dustry
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	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationsh Al Walker / Son				tand Number or Rura Terrace			code) Land 20746
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Commation 4 ☐ Donation ☐ Other (Sp.	3 □Removal from State F+	lace of Dispos emetery, cren Linco	sition (Name of natory or other pla oln Cemet	ery 12/21	10001	. Location - City or To adensburg ,	own, State , Maryland
Balt	permit. Departr Importe any inje		21. Signature of Fineral Service I	Licensee has h.	22	Name and Addre	eorge P. K n Hill Roa	alas Fune d Oxon Hi	ral Home l 11, Maryla	PA and 20745
1	Physician /Medical Examiner	niner	shock, or hear failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	o y U		CANDOU		DISTATE	Approximate Interval Between Onset and Death
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Division		Certification;	3 Suicide 6 Could n 4 Homicide determine		me, farm, stre	eet, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
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Donald Walbert 04-08014

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	Dhuniai		Decedent's Name (First, Miudle	Last)	DOZUL	TIA TH	- GOOG 12	73070	2. Date of D		V	3. Time of Death
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	Director		220-46-7633	1 ⊠ M 2□F	54	Yrs.	Months Days	Hours	Min. JULY 26	5°, 19′50	9. Birthp Cour MD	ntry)
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show important: If item 27 is marked other than "natural", or items 23a or 28e-f show appring yor other treumatic event, the Marical Eventiller intellibed and once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	2 □ No re		Was Decedent of in the state of the state o	an, Mexic	Origin? (Specify Yes or No an, Puerto Rican, etc.) y:		ck, White,	etc.
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п			Southern Mar	vlan	d Hospit	al		Clint	on			Prince	Geor	res
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	3			_		-								1

Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Month	Da		
/Medio		Ethel V. Wilkin 4a. Fecility Name (If not institution, give		<u> </u>	4b. City, Tow	n, or Location of			9,2004 County of Dea	6:50pm ^N
-Adiiii	lei	5001 Boydell Ave	e		Oxon	Hi11			rince G	
ineral rector		5/9-24-6425	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 2 ays Hours	Min. (Month,	Birth Day, Year	9. Bi	rthplace (State or Foreig ountry) aryland
is marked other than "natural", or Items 23a or 28a-f show eumatic event, The Medical Exactinar must be notified at	Director	Usuel Residence of Decedent 10a. State 10b. County MD Prince (ity, Town or Lo	1					10d. Inside City Limit
a or 2	Dire	10e. Street and Number 5001 Boydell Ave			10f. Zip Cod				tizen of What C ited Sta	
r Items 23 Jiner must	Funerai	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent If Yes, specify	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)		14. Race - Am Black, Whi	erican Indian,
atural', o	ted by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2XQ	ccupation		16b. F	Specify: B.	
or than "n	Completed	(Specify only highest grad	College (1-4or 5+)	life.	ndry Aic		of working	P	rivate	
- >	To Be (17. Father's Name (First, Middle, Last) Albert Lyons					's Name (First, Mid mie Wash:			
f item 27 is marked ir other treumatic e		19a. Informant's Name/Relationship (T Ruth Hall /Daught	ter	5001	. Boyde:	11 Ave,0	or Rural Route Nu.			Zip Code)
ant: If iter ury or oth		20a. Method of Disposition XXBurial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Hellioval Itolii State		osition (Name of matory or other Memoria		Date 12-15-04		ocation · City or ndover, N	
Important: If any njury or once		Solova M	Davis				Alexande .E. Wash			neral Home 020
ician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the dealine cause on each line. Colon Ca		ter the mode of	dying, such as c	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
edical		resulting in death)	Due to (or as a consec	quence of):						3 Months
miner	L	Sequentially list conditions,	Congesti		rt Fail	ure				1 Year
ısı	ine	Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
ohysician and the burial-transit	dical Examiner	that initiated events / resulting in death) Last	c. Anemia Due to (or as a consected)	quence of):			¥79.7%			3 Months
by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□	Ectopic pregn			-	23d. Date of de Month	livery Day Year
gned se de	by	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause	given in Part I.				o the cause of death?
cate has been si , page 2 should I	Completed							itopsy irformed?	prior to death?	utopsy findings availab completion of cause of 2 \(\sime\) No
certificate rector, pag	Be	25. Was case referred to medical examiner? 1 🏋 Yes 2 □ No	Hospital:	150/0		Out	of Death (Check on			
: After this e funeral di	ation; To	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	4 □ Nurs Injury at Work? 1 □ Yes 2 □ N	sing Home 5 X Re 28d. Descrit			icify)
ed Director: ad in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str	eet, factory, off	ice	28f. Location City or	n (Street ar Town, State	nd Number or R. a)	ural Route Number,
To the Funerel completely filled	edical	29a. Certifying Phy (Check only 25 Medical Examone)	rsicien: To the best of my known. The basis of examinating and manner stated.	owledge, deatl ation and/or in	h occurred at the vestigation, in r	e time, date and ny opinion, death	place, and due to to n occurred at the time	he cause(s ne, date and) and manner as d place, and due	s stated. a to the cause(s)
To the	Σ	29b. Signature and title of certifier	/ / / ^			ense number		29d. Da	te signed (Mont	, ,
		1' (/ a / 1.	ch, MD		DY	15048		117	1/13/0	11

			For 1_ State	State of M	aryland /	_	artment of H					ODOL	,	5 10
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	lilicate of t	Jeani		Date of Dea	eg. No.	ZUU4	3 Time	of Death
П	Physicia		EDWARD	JAMES	WALK	ŒR.	SR.			Month	Day		1.0.	30P ^M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, or	Location o		ecembe		0, 2004 County of Deat		30F
	Exa.	٠.	Washington Ad	lventist Ho	spital		Takoma I	Park			M	lontogme	rv	
	Funeral			. Sex 7. Ag	e (In yrs. last		If Under 1 Year Months Days	If Under a	Min	Date of Birth (Month, Day	Year)	9. Birt	hplace (State	or Foreign
	Director		226-42-3511	1 M 2 □ F	67_	Yrs.	monano bayo	1,00.0	A	ÙG. 2,	193	7 Vir	ginia	
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside	City Limits
	Mary f sho	Ď	Maryland Montg	omery	D	erwo	od						1 □ Ye	s 2 1 No
	r 28a	Director	10e. Street and Number				10f. Zip Code			1	0g. Citi	izen of What Co	ountry?	
	h with		5904 Muncaste	er Mill Road	d		2085	55			Uni	ted St	ates	
	filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Items 23a or 28a-f show ant, the Medical Examinal must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Orig	gin? (Specif	y Yes or No-		14. Race - Ame Black, Whit		
36	or its	by Fu	1 Never Married 2 X Marrie	1 ☐ Yes 2 ☑ If Yes, Give X			1 ☐ Yes 2 ☑ No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 5.5.,		Specify: Wh		
Ö	hours tural	d be	3 Widowed 4 Divorced	Year or Dates:	1 14	Es Dosse	dent's Usual Occupa	ation			105 1			
75	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done of NOT use retired	during most	t of working		10D. K	ind of Business	industry	
212	d with jiene. r ther	mo	Elementary/Secondary (0-12)	Coltege (1-4or	5+)	Mi	nister						Church	1
ğ	e filed al Hyg othe	Bec	17. Father's Name (First, Middle, L.	ist)				18. Mothe	er's Name (F	irst, Middle,	Maiden	Sumame)		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, Ira Madical Examiner must be notified at	To	Emanuel		Walker	:		Ros	sie			Devers		
Mar	2 shd and is ma reum		19a. Informant's Name/Relationshi				ng Address (Street a							
	1 and Health em 27 ther tr		Dixie M. Walker 20a. Method of Disposition	:/Wife			Muncaster sition (Name of	Mill	1 Rd./			Mary 1		855
JOL	ages nt of the tit it		1 ☐ Burial 2 🗷 Cremation :		ceme	etery, crer	natory or other plac	· 1				•		
altimore,	permit. Pages Department of thimportent: If ite any Injury or of		* 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		Fred		Cremato Name and Address					derick,		
Ba	Depar Impo any Ir		Dayling as 1	1/2/00	(en)		621 Oposs						es, P. 21702	
	#		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause	the death. D							CK, ID	Approxim Interval B	ate
	Physician		Immediate Cause (Final disease or condition	Acu				ailu.					Onset an	d Death
	/Medical		resulting in death)	a	a consequence		21010	011101					1 427	114
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence	ca of):							i mo	.n
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence	ce of):					_	_	1 1713	пти
8760,	icate be executed physician and the burial-transit	dical E		Athen	rosleva	· Fic	Heert	Dise	asa				5 yea	15
9	uficate g phy as the	ledic												
Вох	h cert endin use	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy				1	23d. Date of del	•	
	that the death certifii ed by the attending p detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant a			Other (specify)					Month	Day	Year
P.0.	nat the d by t letach	Phy	9 Unknown		ud not condition	n in the	- d - sh d	en in Deat I		230 Did to	hassa.	use contribute to	the sauce of	f doath?
	es De	l by	Part II. Other significant condition		Diseas	-	idenying cause give	en in Fait i.			es 21			Onknown
Ö	w requir been si should I	etec	V = 100 12.	() CC()	32 (3262)									`
Vital Records,	The lavate has	Completed								24a. Was a autops perforr	5V	24b. Were au prior to death?	completion of	cause of
ta		e Cc	25. Was case referred to medical					26 Place	of Doath /	1 ☐ Yes	2, No	1 Yes	2 No	
>	Physicien: r this certifica ral director, t	0 8	examiner? 1 Yes 2 No	Hospital:	ent 2□ER/	Outpatien	t 3 DOA Othe	26				6 □Other (Spe	cifv)	
J of	ding Phys h. After this funeral dii	n: T	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry 28t	b. Time of Injury	28c. Injun Work			1. Describe ho			//	
Siol	Attendir death. ctor: Af y the fu	atic	2 ☐ Accident investiga	tion				Yes 2 □ I	No					
Division	i or Attendafter death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 200. Flace of III	jury - At home, tc. <i>(Specify)</i>	, farm, <i>s</i> tr	eet, factory, office		28f	Location (St City or Town		nd Number or Ru)	ıral Route Ni	ımber,
	pitel		29a. Certifier 1 1 € Certifying	Physician: To the best	of my knowled	dan daat	annumed at the time	a data an	d place, and	I due to the e			-totad	
	24 ho 24 ho e Fun etely	edical		Physician: To the best ceminer: On the basis of and manner st	f examination	and/or in	vestigation, in my of	oinion, deal	th occurred	at the time, d	ause(s)	and manner as i place, and due	to the cause	e(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier	A 4			29c. License	number		2	9d. Dat	te signed (Monte	h, Day, Year,)
	0		> Oba	Munza	- WO		DI	228.	_	1	Dec.	emher	11,24	100
	3		30. Name and address of person w			a) (Type,	Print) Alfre	ed M	unzer	, MD				
				roll Aven			Koma Pe	ark	MD.	20011	7			
	Sta Registr		31. Date filed (Month, Day, Year) DEC		s Signature	de	Speech)							

			State of Maryland / Department of Health and N	Mental Hyg	iene 2004	41520
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last).	2. Date of Dea	eg. No.	3. Time of Death
	Physicia		Doris Armstrana	Month /	Day Year	0/12 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	00
			5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	MU	Home H	ruldel
g,	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. If Under 24	8. Date of Birth (Month, Day	Year) 9. Birti	nplace (State or Foreign untry)
	ס		Usual Residence of Decedent	1 0/0)	7 7 0	
	anylar show	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 XX No
	the M	ecto	MD ANNE ARUNDEL MILLERSVILLE 106. Street and Number 10f. Zip Code	1	0g. Citizen of What Co	
	3a or	io i	436 MALI COURT 21108		USA	•
	Bms 2	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 17. Marital Status 14. Was Decedent of Hispanic Origin? (Sp. 17. Marital Status 15. Marital Status 16. Marital Status 17. Marital Status 17. Marital Status 17. Marital Status 18. Marital Status	ecify Yes or No-	14. Race - Ame Black, White	
36	s after	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo If Yes, Give 1 ☐ Yes 2XXNo Specify:	, ,		BLACK
8	tiled within 72 hours after death with the Maryland Hygiene. other than "naturel", or items 23a or 28a-f show ont, it s Musical Examination at the mailited at		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	ndustry
215	thin 7: e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ing		
2	led will her the her the		12 PRE SCHOOL TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name	a /First Middle	EDUCATION	I
Maryland 21215-0036	12 should be filed within "n and Mental Hygiene." I'ls marked other than "reumetic event, I'le Men	o Be		MMA SWEA		
ary	shoul	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			lip Code)
	and 2 ealth a n 27 lg		ODELL WILSON 436 MALI COURT, MILLER			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23a or 28a-f show apply injury or other traumatic event, It's Marical Examination at the mailtied at once.		1 X Murial 2 □ Cremation 3XX Removal from State cemetery, crematory or other place)	Date	20c. Location - City or	
量	artmer artmer ortent injury		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service (Specify) 22. Name and Address of Facility FII	NK FIINER	BOWLING GE	
Ba	permit. Departr Importe eny inj		KELAY CREGORY FINK #MU1148 426 CRAIN HIGHWAY			
	4000		23a. P n1. Enter the mode of dying, such as cardiac shock, or heart failure. I st only one cause on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical	1	Immedi le Cause (Final disease et condition resulting in death) a. QTOUGE ++TFEST	-		Onset and Death
	Examiner		Due to (or as a consequence of):			
ш		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events c. tesulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death centificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E	Due to (or as a consequence or).			
9	tificate ig phys as the	ledic	0.			
Box	th cer tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli Month	very Day Year
0.	that the death certifued by the attending to detached for use as	ysici	1 □ Yes 2 No 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	-	I WOTE !	Day Tour
Δ.	res that t igned by be detac	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	w require: been sig should b	ed b	<u> </u>	1 🗆 Y	es 2 No 3 Pro	obably 4 Unknown
ecc	taw re nas be	Completed	DW/	24a. Was a autops	sy prior to d	topsy findings available completion of cause of
	sicien: The law certificate has b irector, page 2 s			perform 1 ☐ Yes	med? death? 2DNo 1 ☐ Yes	2 No
Viital	s certif	o Be	25. Was case referred to medical examiner? 1		ne) ence 6 ⊡Other (Spec	rific)
οr	ding Phys h. After this funeral di	l⊢⊪			ow injury occurred	my)
Siol	ttendir death. ctor: Af / the fu	catic	2 Accident investigation M 1 Yes 2 No			
Division of	or Attendate death Director:	Certification;	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	treet and Number or Ru n, State)	rai Houte Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the c	ause(s) and manner as	stated.
	thin 24	Medical	one) and manner stated. 29b. Signature and title of certifier / Jennifer L. Erich 29c. License number		9d. Date signed (Monti	
	F 3 F 8		DOO47/7	2	12/291	04
	6		30. Name any ddress of perion who completed cause of death (Item 23a) (Type, Print)		2 (1 = 10.0	
			31. Date fied (Month, Day, Year) 32. Registrar's Signature	ten C	DUTTING	
	Sta Registi		JAN 0 3 2005			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Shamin ECEMBER 29, 2004 Ahmed 10:00 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Center Saint Joseph Medical Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Months Days Hours 220-31-8946 48 Pakistan Director 12-12-1956 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 he marked other than "natural" > 1.1. The pages 1 and 10 marked other than "natural" > 1.1. The pages 1 marked ot 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits N/A Balto TX□Yes 2□No Director Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9618 Mason Avenue 21234 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Yes 2√□ No If Yes, Give A Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Asian Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk Unk Elementary/Secondary (0-12) College (1-4or 5+) 12 th grade 4 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sabra Bagam Mohammad Khan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rashid A. Khan - Son 9618 Mason Avenue Balto, Md 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State King Mem Park 12/30/2004 Randallstown, Md Ponation 5 Other (Specify) ture of Funeral Service License 22. Name and Address of Facility 21. \$ign March F/H West 4300 wabash Avenue Balto, Md 21215 23a. Pairl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC COLON CANCER YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has certificate 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifie 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o one) and manner stated. the 29b. Signature 29c. License number 29d. Date signed (Month, Daf, Year) ပ 100ma D36814 30. Name and address of person who completed cause of death (Item 23a) ER DRIVE TOWSON MARYLAND 21204 M. D. 31. Date filed (Month, Day, Year) 32. Aegistrar's Sign State 0 2005 Registrar

			. FOI	Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 4152
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary Jane Armentrout	2. Date of Death Month December 30, 2004 09:50am M
}	/Medic Examir		4a. Facility Name (If not institution, give street and number) 6319 Georgetown Boulevard Unit-G	4b. City, Town, or Location of Death Eldersburg 4c. County of Death Carroll
	Funeral Director		5. Social Security Number 578-01-6951 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last bin	rithday) If Under 1 Year If Under 24 Hrs. Annual Months Days Hours Min. Dec. 23, 1917 Washington, DC
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town MD Carroll	wn or Location 10d. Inside City Limits Eldersburg 1 □ Yes 2 No
	3a or 28	Il Dire	10e. Street and Number 6319 Georgetown Boulevard Unit-G	10f. Zip Code 10g. Citizen of What Country? USA
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, Ira Medical Extra instructional burnellised at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ □ No If Yes, Give A Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: Specify: White
21215-0036	filed within 72 ho Hygiene. Ithar than "natur ent, Ing Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical Work Social Security Admn.
Maryland 2	2 should be filed and Mental Hygid is marked othar aumatic avent, I	To Be C	17. Father's Name (First, Middle, Last) Edward W. Kober	18. Mother's Name (First, Middle, Maiden Sumame) Anna A. Dowell
	and 2 sho saith and n 27 is m			b. Mailing Address <i>(Street and Number or Rural Route Number, City or Town, State, Zip Code)</i> 962 Quail Run Drive Perry Hall, MD 21128
Baltimore,	9 O == =			of Disposition (Name of any, crematory or other place) View Mem. Park 1/3/2005 Sykesville, MD
Balt	permit. Pag Department fmportant: 1 any injury conce.		21. Signature of Funeral Service Licensee Buan L. Hay G	22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do nead the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Obset and Death Plants of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Obset and Death Plants of the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Obset and Death Plants of the mode of dying, such as cardiac or respiratory arrest,
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.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and to has 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify) Month Day Year
Δ.	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in Malabs or ptime	
Vital Records,		Completed	•	24a. Was an autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \] 2 No
Division of Vita	Attanding Physicien: Th r death. ector: After this certificate by the funeral director, pag	Certification: To Be	1 Natural 5 Pending (Month, Day Year) II	26. Place of Death (Check only one) utpatient 3 DOA Cther: 4 Nursing Home 5 esidence 6 Other (Specify) Time of Injury Mork? M 1 Yes 2 No
Divis	tel or Attand s after death af Director: , ad in by the f	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office 28f. Location (Street and Number or Aural Aoute Number, City or Town, State)
	To the Hospitel or Atta within 24 hours after de To the Funerel Directo completely filled in by th	edical	(Check only 2 Medical Examiner: On the basis of examination and	e, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To with	W	29b. Signature and title of certifier 300 at m	29c. License number 29d. Date signed (Month, Day, Year) 12/30/04 (Type, Print) Ceryston Glvd, Fldersbyg MD + 789
	γ\		30. Name and address of person who completed cause of death (Item 23a) (STEVEN 5, 1976)	Georgeon Blow, Fldersby MD+789
	Sta Registr		31. Date filed (Month, Day, Year) 32. Redistrar's Signature	: Sparle

		1 State Registrar	e (First, Middle, Las				rtificate of	Health and I Death	2. Date of D	Reg. No.	004	3. Time of Death
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Exam	iner		If not institution, give		umber)			or Location of Death	1		unty of Deat	
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after o	Ē		ied 2 Married	Armed F 1 ☐ Yes	2 XN o				o Rican, etc.)		Black, White	e, etc.
72 hours af	1 by	3 🗆 Widowed		If Yes, G Year or I	Dates:		1□Yes 2√2No	Specify:		Sp	ecify: W	hite
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D D 9	ပိ	17. Father's Name	(First, Middle, Last)		8	Phys	ician	18. Mother's Nan	ne (First, Middle		dical mame)	
	To Be	Robert	J. Audi					Diane	Wilkin	son		
2726	-	19a. Informant's N	ame/Relationship (Турө, Print)		19b. Mailir	ng Address (Street	t and Number or Ru	ral Route Numb	ber, City or To	wn, State, Z	(ip Code)
i, ivida and 2 st salth and n 27 is n		Dr. Fre	ederick R	acke		16137	7 York F	Rd., Spar	ks, MD	21152	2	
) <u> </u>		20a. Method of Dis	position Cremation 3	Removal from	ļ	. Place of Dispo cemetery, crer	sition (Name of matory or other pla	12	2/30/04	20c. Locati	on - City or	Town, State
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requires that the deben signed by the		Part II. Other signi	ficant conditions o	ontributing to	death but not r	esulting in the u	nderlying cause gir	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
requires een sign hould be	d by								1 🗆	Yes 2□N	o 3 🗆 Pro	obably 4XIUnknown
law requires as been sign	Completed								24a. Was	san 2	4b. Were au	topsy findings available
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vician: Thisician: The certificate	a)	25. Was case refer	rred to medical		_			26. Place of Dea	1 ☐ Yes	2 X No	1 🗆 Yes	2 No
99 //-	To B	examiner? 1 ☐ Yes 2 🗶	No	Hospital: 1	Inpatient 2	☐ ER/Outpatien	t 3 DOA Ot	L	ome 5 Res		Other (Spec	ity) HOSPICE
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l or Attending after death. Director: Afte	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	289. Plac	e of Injury - At ding, etc. (Spe		eet, factory, office		28f. Location City or To	(Street and N. wn, State)	umber or Ru	ral Route Number,
pitel ours a srel Dilled i		20- 0-45	AT Continue Di	ili								
DIVISION DIVISION THENDING OTHER HOSPITED OF ATTENDING OTHER FUNDER DIRECTOR: AIT OTHER HOSPITED OTHER OTHER HOSPI	edical	29a. Certifier (Check only one)	Medical Exam	niner: On the I	ie best of my k basis of exami nner stated.	nowledge, death nation and/or in	n occurred at the ti vestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	manner as ce, and due	stated. to the cause(s)
To the within 2 To the complet	Mec	29b. Signature and	I title of certifier	and mai	mor stated.		29c. Licens	se number		29d. Date si	gned (Month	n, Day, Year)
F ≯ F ŏ			- /M-				DL	19725		121	127/	04
di		30. Name and add	ress of person who	completed cau	use of death (It	em 23a) (Type.	Print)	10103	Ann			-
1,			IQ MAHMOO					TIMONIUM,	MD 210	193		
	tate	31. Date filed (Mon			Registrar's Sig							

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DECEMBER 27, 2004

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	Dhyaini	20	1. Decedent's Name (First, Middle, La						2. Date of D Month	eath Da	ıy Year	3. Time of Death
	Physici /Medic	al	Richard Lee A				4b City Tourn	or Location of Death	Decem		23, 2004 County of Death	
	Examin	er	921 Top View Dr.	o stroot and nombory			Edgewo		,		Harford	
8	Funeral Director		213 00 2324	Sex 7.Ag	9 (In yrs. 34	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D March	ay, Year,		nplace (State or Foreign untry) aryland
	hand ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	e Mary	Director	Maryland Baltim	ore	E	dgewood	1			,		1 ☐ Yes 2X☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Medicul Ever, it ar must be notified at once.		10e. Street and Number 2604 Thornber				10f. Zip Code 21040				itizen of What Cou	Α.
	ltams	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣		.S. 13. \	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No ORican, etc.)	10-	14. Race - Amer Black, White	
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Maryland 21215-0036	should nd Mer marke matic	2	Richard L. Ai 19a. Informant's Name/Relationship			19b. Mailir	g Address (Street	EyVOIIII	e Morri		or Town, State, Z	ip Code)
, Na	and 2 salth at a 27 ls ar trau		Rhonda Robins	on, sister		1638	Bedford	d Rd. Gle	n Burni	e, M	D. 2106	1
Baltimore,	it of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			emetery, crer	sition (Name of natory or other pla		Date		ocation - City or	
it in	artmer ortant injury		4 □ Donation 5 □ Other (Special Signature of Funeral, Service Lice		LO	udon Pa		12- ess of Facility Funeral H	28-04		ltimore,	MD.
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876	certificate be ex Iding physician Ise as the burial	dlcal		d								
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	the death the atter	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnand Other (specify) _				Month	Day Year
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cor	aw requ s been 2 shou	Completed							24a. Wa		24b. Were au	topsy findings available
Re	The la ate ha	Com							1 X Yes	opsy formed? 2□ No	death?	topsy findings available completion of cause of 2 No
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of	g Phys er this neral di	n: To	1 ☑ Yes 2 □ No 27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	1 3LI DOX	4 Nursing F	28d. Describe			at scene
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_	To the within. To the comple	Me	29b. Signature and title of certifier					se number			ate signed (Month	
			+ Hamek Der	shalf M)		00	CME		De	cember 2	4, 2004
	15/		30. Name and address of person who	11-11 200			111 D	enn Stree	t, Balt	imor	e, MD 21	.201
		ate	31. Date filed (Month, Day, Year)	32. Registi	ar's Signa	ature	L.E				,	
	Regist	rar	JAN 0 3 2005	STAN	10	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 9:50 A.M. ANNA LOUISE BALDWIN 30 2004 1) e cember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 8/15/1925 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 💢 🏋 79 MARYTAND Yrs. Director 215-22-5590 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked othar than "natural", or itams 23a or 28a-f show othar traumatic avent, the Medical Examinar must be notified at Funeral Director MD ANNE ARUNDEL PASADENA 1 ☐ Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8016 RITCHIE HIGHWAY, APT 2 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 2 3 1 1 ☐ Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXVo WHITE Be Completed by 3XXWidowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentat F GEORGE FREDERICK MURPHY ANNA LOUISE EBBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 Is
any injury or othar trau CHARLES R. BALDWIN - SON 801 RUCKSHIRE DRIVE, ARNOLD, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages XXBurial 2 Cremation 3 Removal from State MARYLAND VETERAN CEM 1/3/2005 CROWNSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility FINK FUNERAL HOME, PA 90 Funeral Service KELLY GREGORY FINK 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 #MO1148 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed 10 Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1XInpatient 2 EN/Outpatient 3 DOA 27. Manner of Death 1 Natural te of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No Z □ Accident investigation after death in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

m).

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Glan Burme

December of Character Dece				1 = For State Registrar	State of Marylar	nd / Depa	artment of H	lealth and Death	Mental Hy	giene	004	41526
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Provision (Microscape Section 1987) Provision (ore	ges 1 t of He If item or oth				Place of Dispo cemetery, crer	esition (Name of matory or other plac	e)	Date	20c. Locati	on - City or To	wn, State
Provision (Microscape Section 1987) Provision (ΞË	rtmen rtent:		4 Donation 5 □ Other (Specify)	Mt				23/04	Balti	.more,	Md
Physician Microscient Control of the	Ba	Depa Impo any is		21. Sixtato di Funeral Service Licens	NX ok	Ma	irch F/H	West	D . 1 6 1			
Physician Medical Examiner Part Comparison Compari	3	*		23a. Part 1. Enter the disease, or compless or heart talking. List only of	cations that caused the deal	th. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	more, rest,	Ma 2	Approximate
Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Control Con		Physician		tmmediate Cause (Final	ADR	E as A	1 (6	2101	6			Onset and Death
Sequentially list conditions are a consequence of): Sequentially list conditions are a consequence of):	*			resulting in death)	Due to (or as a consec	quence of):		- (0,3 (
The state of the s	Ď,	%.E	<u>a</u>	Sequentially list conditions,		wance of:						
Section Sect		uted d ansit	min	Cause (Disease or injury		,						
FFEMALE: 230. Was decadent pregnant 1 1 1 2 1 2 2 1 2 2	, O	e exec ian an urial-tr	Exa	resulting in death) Last		quence of):						
See that the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown					l							
See that the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown	9 x c	certifi nding use as	√Me		3c. If yes, outcome of pregna	ancy				23d	Date of deliver	nv.
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Nonth, Day Year) Section Continuous C	ds,	ires th signed	þ	CAF HA	itributing to death but not res			en in Part I.		4/		
Nonth, Day Year) Section Continuous C	COL	w requ	iete	PAN HUD	DITUR	1 (/	m .					,
Nonth, Day Year) Section Continuous C	Re	The la te has age 2	ошо	1-140,51	1.18.001	(m	, , ,		autop perfor	med?	prior to con death?	pletion of cause of
Nonth, Day Year) Section Continuous C	ita	ian: ortifica ctor, p			1910101	- /)		26. Place of Dea		1	ILI Yes	2
Nonth, Day Year) Section Continuous C	<u>></u>	hysic this ce	ို	1 ☐ Yes 2 ☐ No	1 Anpatient 2		IL JUDA	4 Nursing F	tome 5 ☐ Resid	ence 6 🗆	Other (Specify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Kay Schipton Print)	uc Ouc	ding P	ion:	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		Work	(?	28d. Describe h	ow injury oc	curred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Kay Schipton Print)	/isi	Attender death	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str		2 140			Imber or Rural	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Kay Schipton Print)	ă	rs after el Dire	Cert	4 Homicide	building, etc. (Special	(y) 			City or Tow	m, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) The Kay Schipton Print)		e Hospi 24 hour e Funer letely fill	dicai	(Check only 2 Medical Exami	101: On the basis of examina	owledge, death ation and/or inv	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	and due to the curred at the time, c	ause(s) and date and place	I manner as sta ce, and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) This backar Schipperson (Item 23a) (Type, Print)		To th withir To th comp	Me	29b. Signature and title of certifier		· .						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. Name and address of person who completed cause of death (Item 23a) (Type, Print))	ś		Annual An			DI	-4100	Î	2-	15-3	1004
3,1-1201				30. Name and address of person who co	4 4 1 4	p-granules.	Print)	z m u n	7 DCF	105	BAI	MALIZ
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	\$ '			31. Date filed (Month, Day, Year)			Coastes	100	/ /	•		17-12-61

	1	1- For Amend Item 1& Plate of Maryan 683 spartings of Health and Certificate of Death		Reg. No.	14 41527
Physician /Medical		1. Decedent's Name (First, Middle, Last) Doris Berryman Berrymam	2. Date of De Month DECEMB		3. Time of Death 5:05 P M
Examiner		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea 4c. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea BALTIMORE CITY		4c. County	
uneral rector		5. Social Security Number 219–28–0168 6. Sex 1 7. Age (In yrs. last birthday) 1 1 Under 1 Year 1 Under 24 Hr. Months Days Hours Min		rth av. Year) 32	9. Birthplace (State or Foreign Country) Md.
Mol I	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
r 28a-f show notified at irector	3	Md. NA Baltimore			1X Yes 2 No
23e or 2 uni be no	5	10e. Street and Number 10f. Zip Code 6401 Lock Raven Blvd. Apt. 201 21239		10g. Citizen of W USA	/hat Country?
ar, or Itema	2	11. Marital Status 1	Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	e - American Indian, k, White, etc. White Black
Medical	non-in-	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade 15. Decedent's Usual Occupation (Give kind of work done during most of wo	orking	Baltimo	ore City Paper
event,		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		, Maiden Sumam	*
other traumatic event, the To Be Com	2	William C. Berryman Loret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F		1.	Callahan
rtraur		Mezette Meredith Niece 3406 Walnut: Drive,			
any Injury or other		20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) New Cathedral Cem. 1-	Date -3-05		City or Town, State
any Inju		21. Signalure of Funeral Service Cig. see 22. Name and Address of Facility March F.H. East		imore, M E. North	
ician dical niner	5	23a. Part1. Enter the disease, or come Cations that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List of on cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DI Due to (or as a consequence of): Sequentially list conditions, it any, reading to attribute to the mode of dying, such as cardia the death. Do not enter the mode of dying, such as cardia the death. Do not enter the mode of dying, such as cardia the death. Do not enter the mode of dying, such as cardia the death. Do not enter the mode of dying, such as cardia the mode of dying the mode o			Approximate Interval Batween Onset and Death
as the burial-transit	Lvall	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.			
be detached for use as by Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date Mon	e of delivery hth Day Year
		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
rector, page 2 should the Completed I	and in or		24a. Was auto perfo 1 🗆 Yes	psy pr prmed? de	Vere autopsy findings available rior to completion of cause of eath? Yes 2 No
ector.	2	examiner?	eath (Check only	1 2 2 2	er (Specify) SCENE
ufter this uneral d	- 60	27. Manner of Death Month, Day Year 28b. Time of Injury 28c. Injury at Work? Accident 28a. Date of Injury 28b. Time of Injury 4 Work? Month, Day Year 28b. Time of Injury 4 Work? 1 Yes 2 No		idence 6 V Othe how injury occurre	1-227
led in by the funera		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To	Street and Numbe wn, State)	er or Rural Route Number,
pletely fill	מונים	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and the occurred at the occurred at the time, date and the occurred at t	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
Moo /		29b. Signature and title of certifier Notheric The Unite Man 29c. License number O C M E			(Month, Day, Year) 25, 2004
9		Name and addr ss of person who completed cause of death (Item 23a) (Type, Print) NARGARITA KORELL, MD 111 PENN STREE	T, BALTI	MORE, MAI	RYLAND, 21201
State Registrar	;	31. Date filed (Month, Day, Year) 3 2005 32. Figistrar's Signature			

State of Maryland / Department of Health and Mental Hygiene 41528 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Butler **Physician** Κ. Herman DEUSMBER 24 2004 8.16 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 ☐ F 55 Md. 220-50-0246 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f ahow other traumatic event, the Medical Examinar mant be notified at 1X Yes 2 □ No Director Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 3211 Guilford Ave. by Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married within 72 hours after Specify: Black Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer GED Pages 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be t of Health and Menta Butler Rosa Wesley ္က Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Diener Place, Baltimore, Md. Today Butler Daughter Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c Location - City or Town State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Randallstown, Md. King Mem Park 12-31-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ARDIO PULMONARY /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Liter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit Due to (or as a consequence of): attending physic IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the th detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ ARTERY DESEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☒ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 ⊠Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 Hoapital 29a, Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Fune (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOO (al MID Now DELEMBER 24 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCHRAVEN BLUD, BALTIMORE MD 21239 5601 NORONHA 3 Registrar's Signature 31. Date filed (Month Day, (rea)) State Registrar

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REMAN

			-	ate of Maryland / Depa Cer		th and Mental Hy	
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) William 4a. Facility Name (If not institution, give street Maryama 57emes	and number)	ennett 4b. City, Town, or Locat	2. Date of Dea Month Decemb	th 3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex 214-30-6493 X	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)		nder 24 Hrs. 8. Date of Birt	9. Birthplace (State or Foreign Country) S.C.
	ath with the Maryland 123a or 28a-f show	ector	Md. 10b. County NA 10e. Street and Number	10c. City, Town or Lo	altimore		10d. Inside City Limits X□Yes 2□No 10g. Citizen of What Country?
2-0036	ours after dea el', or Items Examiner	ted by Funeral Director	1118 Whitelock Str 11. Marital Status 1 □ Never Married	/as Decedent Ever in U.S. med Forces? If U.S.	21217 Vas Decedent of Hispanic Yes, specify Cuban, Mex	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	USA
Maryland 21215-0036	s 1 and 2 should be fited within 72 hc f Health and Mental Hygiene. item 27 is marked other then "natur other traumatic event, the Madical	Be Completed by	(Specify only highest grade con Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) William	ollege (1-4or5+) Bennett, Jr.	18. N	Mother's Name (First, Middle, Julia	Center People Community Healt Maiden Sumame) McKnight
Maryla	1 and 2 should be f Health and Mental H Iem 27 is marked of other traumatic eve	2	19a. Informant's Name/Relationship (Type, F Daisy Bennett	Print) 19b. Mailin	g Address (Street and Nu		r, City or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2' any injury or other once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Car	mel Cem.	Date 1-3-04	20c. Location - City or Town, State Dundalk, Md.
Ball	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	M	Name and Address of F arch F.H. E	ast 1101 E	ltimore, Md. 21202 . North Ave.
68760,7	/Medical Examiner and physician and physician and physician and the bruil-transit	dicai Examiner	23a. Part1. Enter the disease, of complication shock, or heart failure. List only one call the complex of the c	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Infaect	ron	Inferval Between Onset and Death
P.O. Box 6	that the death certificated by the attending phy detached for use as the	ysician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Vital Records, P.	The law requires ate has been sign page 2 should be	Completed by Physician/Med	Pagli. Other significant conditions contribu Henal Disease Can cla of uni	ting to death but not resulting in the un - COAGUIOPA KNOWN TYP	thy,	1 U Y S 24a. Was a autop perfor	prior to completion of cause of death? 22 No 1 Yes 2 No
Division of Vit	tending leath. tor: After the fune	Certification: To Be	Natural 5 Pending 2 Accident investigation	al: 1 Inpatient a. Date of Injury (Month, Day Year) Place of Injury - At home, farm, stre building, etc. (Specify)	28c. Injury at Work? M 1 Yes	2 🗆 No	ence 6 Other (Specify) ow injury occurred treet and Number or Rural Route Number.
D	To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by	Medical Cer	(Check only /2 Medical Examiner: (n: To the best of my knowledge, death	occurred at the time, dat estigation, in my opinion,	te and place, and due to the dideath occurred at the time, of	ause(s) and manner as stated. late and place, and due to the cause(s)
		Me	29b. Signature and title of certifier * Claim Fr	iziar, mo	29c. License numb	43 °	29d. Date signed (Month, Day, Year)
	J-		30. Name and address of person who comple Elame FRAZICK, //	ted cause of death (Item 23a) (Type, I	Pland Gre.	neral Hesp	12/27/04 01 tal
	Sta Registr		JAN 0 3 2005	32 Aegistrar's Signature	de		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Physici	an	1. Decedent's Name (First, Middle, Last	BI						2. Date of De Month	Day	Year ,	3. Time of Death
	/Medic		Charles	Deas/e	У			7	0: 7	12	201	004	0135p
1	Examin	er	4a Facility Name (If not institution, give	1 1/:1-	2			4D	Bollen	ocetion of Death			/
			F Social	rles VIIIage		th do. 1	If Under 1 Y	Car	If Under 24 Hrs.	1 CIFY		NA	
	Funeral Director	8	223-20-1405	x 7. Ag b {In yi				ays	Hours Min.	8. Date of Birl (Month, Da 10-26	y, Year) -19	9. Birthpli Count	ace (State or Foreign ry) Va.
	pua ≱	-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town	n or Loca	tion					10	d. Inside City Limits
	Alenyta P aho	5	M.J. NIA		•								1∭ Yes 2□No
	the h	Director	Md. NA			ватт	imore				10g. Citizen of	What Count	rv?
	with a second			71					_				
	eath na 23	era	2327 N. Charles S	12. Was Decedent Ever in	U.S.	13. Wa		121 of His		pecify Yes or No o Rican, etc.)	USA 14. Rad	e - America	ın Indian,
Maryland 21215-0020	72 hours after death with the Meryland natural', or tems 23a or 28a-f ahow nated Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:			es, specify (o Rican, etc.)	Bla Specif	ck, White, e	ack
50	72 hours "natural", vical Exc	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a.	Deceder	nt's Usual Oc	ccupat	ion	kina	16b. Kind of B	usiness/Ind	ustry
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7	filed withi Hygiene. other then	5	6th grade			Self	Emlo				Contr		
nd	8 E E S	Be	17. Father's Name (First, Middle, Last)	_				_ 1		ne (First, Middle,			
Z a		٩	Daniel		asley				Anna			heath	
Jar	2 sh end ls m		19a. tnformant's Name/Relationship (Ty							ral Route Numbe		State, Zip	Code)
	1 end Health em 27	- 1	Ernest Royal	Brother	4				Ave., I	Baltimor		2121	
Baltimore,	T of or		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 ☑ Donation 5 □ Other (Specify)		cemeter	y, crema	ion (Name o tory or other Nount (place)		Date	20c. Location	-	
atti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licens	ee / a.a. /			Inme and Ad				more, M		1202
œ	89 E 8	í	(Lond P	Malleras	1		March	F	H. East	110	7 77 37		
	C 2010	1	23a Par 1. Enter the disease, or complished, or heart failure. List only or	ications that caused the	ath Dor	not enter	the mode of	dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between
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-4	/Medical		Immediate Cause (Final disease or condition	Thorac	10	A	ovti	10	Ane	HVV 5	M		
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	requires that the death certificate be executed even signed by the ettending physician end hould be deteched for use as the bunel-transit	Examiner	Sequentially list conditions,	Dua tu	(ur as a c	unsches	nes of).						
68760,	oe exe		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									Į Į	
87	sete b	Medical	that initiated events resulting in death) Last	Due to	(or as a c	onseque	nce of):						
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	the de	Physician/	Part II. Other significant conditions con	tributing to death but not re	esulting in	the unde	erlying cause	e given	in Part I.	23b. Did 1	/		tha cause of death?
P.0	that the de ned by the e	된	Hy per Tell	1510n						10	Yes 2 Mo	3 ☐ Prob	ably 4 ☐ Unknown
Division of Vital Records,	uires tha signed Id be del	d by	. 1							24a, Was	an autopsy	24b. We	re autopsy findings
2	v require been sig	Completed	WICEVATI	NE COI	1 4	5				perfo	rmed?	com	ilable prior to apletion of cause eath?
Be	The law ate hes b page 2 s	티								40	res 2 No	1	
a			25. Was case referred to medical						00 DI	101		1	Yes 2□ No
⋚	Physician: r this certific ral director,	o Be	examiner?	fospital: 1 Inpatient 2		to a ti a m t	3□ DOA	Other	. /	th <i>(Check only o</i> ome 5 ☐ Resid		(0:4)	
of	Phys rthis	1. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)		·		Injury a			now injury occur		
O	ding th. After fune	ţ.	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Ir	njury			es 2 No				
<u>isi</u>	or Attending after death. Director: After I in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, fai	rm, street	t, factory, off	lice			Street and Numb	er or Rural	Route Number,
ā	affor A affor Direction of in b	Certification:	4 ☐ Homicide	building, etc. (Spe	cify)					City or Tov	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edlcai (sician: To the best of my kiner: On the basis of examin									
	To the I within 2 To the I complet	Med	29b. Signature and title of certifier	and manner stated.			29c. Lic	cense r	number	T	29d. Date signe	d (Month, E	Pay, Year)
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	\	-	30. Name end address of person who co		em 23a) /	Type D-	nt)			- 1 -	Decem 1	JEY 4	- 200 7
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	idge Me 22. Name an	em. Park 1	Hubba	ard Fune	eral Home	, Inc.		
Frank Bain 19a. Informant's Name/Relationship (Type, Print) Harry Bain / Brother 20a. Method of Disposition 1 Removal from State Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard I 4107 Wilkens Avenue, Ba								
20b. Place of Dis		en Choice	Lane,		VIIIe, Ma Location - City or			
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	Secret	18. Mother		rst, Middle, Mais		110015		
(Gi	a. DO NOT us	rk doné during most se retired)	of working		Baltimor Public Sc	e City		
	1 ☐ Yes		gin? (Specify , Puerto Rica		14. Race - American Indian, Black, White, etc. Specify: White			
	10f. Zip	21228		10g.	Citizen of What Co United			
10a. State 10b. County 10c. City, Town or Life Maryland Baltimore Cate 10e. Street and Number 406 Maiden Choice Lane						10d. Inside City Limits 1 ☐ Yes 2 💥 No		
	Months	Days Hours	Min.	pate of Birth (Month, Day, Yearch 15	9. Bir , 1923 N	thplace (State or Foreign ountry) faryland		
4a. Facility Name (If not institution, give street and number) Ridgeway Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)						more		
	4h City	Town or Location of	De	27 2004	6:12 P M			
	eruncau	e or Death	2.	Date of Death		3. Time of Death		
(1	ln yrs. last birthd	4b. City, Cat In yrs. last birthday)	4b. City, Town, or Location of Catonsville In yrs. last birthday) If Under 1 Year If Under 1 House In Year	4b. City, Town, or Location of Death Catonsville In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.1	4b. City, Town, or Location of Death Catonsville In yrs. last birthday) Months Days Hours Min. 2. Date of Death Month December	Month Day Year December 27 2004		

State of Maryland / Department of Health and Mental Hygien 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Carlita A. Bayton December 30 26 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 0 hmos Singi Hospil NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 06-24-1952 Maryland 212-60-7688 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-1 show item 27 is marked other than "natural; or items 23a or 28a-1 sho other traumatic event, the Marilea Experiment rust by molified at NA Baltimore 1XYes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 Violet Avenue Apt 403S 21215 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ☐Yes 2[X]No Yes, Give 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: à 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 h and Mental Hygiene. 71s marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Thomas Hopewell Shirley Hopewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Department of Health a Important: If item 27 is any injury or other tra 2503 Violet Avenue Apt 403S Baltimore, MD Bruce R. Bayton/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 11 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 01-05-05 Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23d. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final In backani Pnysician one day disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions in the cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) been signed by the s should be detached t Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 autopsy performed? 2 No 1 Tyes or Attending Physician: After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ach -000 26,2004 h 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) KHAWAJA-A-FARCOOL 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 0 3 2005 Registrar

		•	1 - For State Registrar		f Marylar		artment of I				giene Reg. No.	004	415	33
	Physici	an	1. Decedent's Name (First, Midd							2. Date of De. Month	Day	Year	3. Time o	
	/Media	al	Kelley S. Bracke 4a. Facility Name (If not institution		mber)		4b. City, Town,	or Location	of Death	12	2-7 40.00	2-06 i unty of Death		4 P M
	Examir	ier	Union Memorial Hos	-	inoer)		Balti		OI Dealii		40.00	NA		
	Funeral		5. Social Security Number	6. Sex	If Under 1 Year	If Under	24 Hrs.	8. Date of Bird (Month, Da	h Your	9. Birth	place (State	or Foreign		
	Director		213-94-5302	1□M 201F	25	Yrs.	Months Days	Hours	Min.	08-08-19	79	Maryl	and	
	and w		Usual Residence of Decedent 10a. State 10b. Count	y	10c. Cit	ty, Town or La	ocation						10d. Inside C	ity Limits
	Maryl.	ō	10a. State 10b. County 10c. City, Town or Location MD NA Baltimore											2 🗌 No
	r 28a	irec	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?	
	th with	Funeral Director	1210 Gittings Ave	nue			21:	239				USA		
	r dea	ner	11. Marital Status	Armed Fo	edent Ever in U orces?	.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White		
36	s afte		1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Gi	ve		1 ☐ Yes 2 🛣 No							
9	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examinat must be multised at	edt		nt's Education		16a. Dece	dent's Usual Occu	pation			16b. Kind	Blac of Business/Ir		
215	within 72 iene. then "na the Media	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during mos d)	t of workir	ng			·	
21	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, the Medical Exemples must be retified at	Completed by					Janitor					Airpo	rt ————	
Baltimore, Maryland 21215-0036	be fill tal Hy od oth	Be	17. Father's Name (First, Middle	, Last)						(First, Middle,	Maiden Sui	mame)		
7	ges 1 and 2 should be t of Health and Mental If item 27 Is marked o or other treumatic eve	^C	Emanuel Okwaraji 19a. Informant's Name/Relation	shin (Tyne Print)		19h Mailir	ng Address (Stree			Bracken	or City or To	oue State Zi	n Code)	
Ma	nd 2 sho Ith and 27 Is ma	i i	Denise A. Bracken		er		Paul Martin					wii, State, Zi	p Code/	
re,	of Health item 27 other tr		20a. Method of Disposition		20b. F	_ Place of Dispo	sition (Name of natory or other pla	1		ate		ion - City or T	own, State	
E O	Pages nent of I ont: If it ury or o		1 ∯Burial 2 □ Cremation 14 □ Donation 5 □ Other (State		ar Cemeter		2-31-0	4	Cato	nsville.	, MD	
ati	permit. Page Dep rtment of Importent: If any njury or once.		21. Signature Funeral Service	Licensee	111	22	2. Name and Addre	ess of Facili	ty					
	82 = 29		MAJA				Wylie Funer					t Balto	, MD 212	17
J.			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that it only one cause on e	aused the deat each line.	h. Do not ent	er the mode of dyi	ng, such as	cardiac or	r respiratory ar	rest,		Approximat Interval Bet Onset and	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)			HTIV	ACINET	OBA	CTER				Ondot and	
	/Medical Examiner		Todaking in Today,		(or as a conseq			- 0					a factor	
		E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Tue to	b. PULMONARY EMBOLISM Due to for as a son sequence off:								.144.0	-03
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	DE	· DEEP VEIN THROMBOSIS									lays.
Ó,	ate be executed hysician and the burial-transit		resulting in death) Last		(or as a conseq									9
8760,	ate hys the	lical		d.										
9	death certific e attending p id for use as l	Physician/Medical	IF FEMALE:	23c If yes out	tcome of pregna	ancv								
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	oirth 2 Feta	Ideath 3	Ectopic pregnance Other (specify)	у			230.	Date of deliv Month		Year
0	t the de by the a	nysl	1 □ Yes 2 ☑No 9 □ Unknown	9□ Unkn										
٣.	requires that the een signed by th nould be detache	by Pl	Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the u	nderlying cause gr	ven in Part I	4	23e. Did to	bacco use o	contribute to t	he cause of c	death?
ıd	w require been sig should b									1 □ Y	′es 2 □ N	o 3 ☐ Proi	bably 4 💢	Jnknown
of Vital Records,	S b	Completed								24a. Was autop	sv	4b. Were auto	opsy findings empletion of c	
E B		Con				_				perfor	med? 2 No	death?	2 No	
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			0#	200		(Check only o				
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Division	or Attendi after death. Director: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could	mined 286. Place	of Injury - At he	ome, farm, str	eet, factory, office		2	8f. Location (S City or Tow		umber or Run	al Route Num	iber,
Ö	tel or A	Cert	4 Homeldo	buildi	ing, etc. (Specin	y/ 				City of Tow	n, State)			
	Hospitel or 24 hours after Funerel Dire stely filled in t	edical	29a. Certifier 1 Certifyi	ng Physician: To the I Exeminer: On the b	best of my kno asis of examina	wiedge, death	occurred at the ti	me, date an	d place, a	nd due to the o	ause(s) and	manner as s	tated. o the cause(s	:)
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifi	and man	ner stated.		29c. Licens					gned (Month,		
	5 ₹ 5 8		230. Signature and time of continu						/ 5	.13				
7	1		30. Name and address of person	- USMA		D .				ORIAL				(
	9		DR. S.A. U		7		NIVERSITY							-18
	Sta		31. Date filed (Month, Day, Year) 32. P	legistrar's Signa	iture								
	Registi	ar	JAN 0	3 2005	Busines.	As he	oute						_	

			1 - State Registrar	State of	of Marylar	-		t of He	ealth and l Death	Mental Hy	/giene Rog. No	2001.	1.1531.
	Physici		Decedent's Name (First, Middle, Las Steven L. Boyd	t)	_					2. Date of De Month	eath / aDav	74 7 Xear	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give Mary land Gre	street and ny	imber)	sital	Ab City,	Town, or L	ocation of Death	-		County of Deat	h
	Funeral Director		5. Social Security Number 6. St 214-64-6231 1. Usual Residence of Decedent	X ÖM 2□F	7. Age (In yes. 45	last birthday) _ Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D. 03-28-1	rth ay Year) .959	9. Birt <i>Co</i> Mary	hplace (State or Foreign untry) Land
	yland		10a. State 10b. County		10c. Ci	ty, Town or Loc							10d. Inside City Limits
	he Mai	Director	MD	NA		Ba	altimo						1 X Yes 2 □ No
	3a or 2	Dir	10e. Street and Number 2412 St. Paul Stree	t			10f. Zip	218			10g. Citi	zen of What Co USA	untry?
ဖွ	s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I health and Mental Hygiene. It is marked other then "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Essaulter nust be notified at	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi	2 No	If	/as Deced	ent of His ify Cuban	panic Origin? (Si Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	rican Indian, e, etc.
-0036	hours tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or D	Dates:	,			Specify:		1 101 10	Specify: Bla	
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221	iled wil Hygien ther th		12. 17. Father's Name (First, Middle, Last)		,	We	elder		9 Mathada Nam	o (First Middle	Maida		all preer
lanc	2 should be filed with and Mental Hygiene is markad other tha aumatic avant, Ire I	To Be	Charles Boyd						8. Mother's Nam Mary Jack		, Maiden	Sumame)	
$e\mathcal{R}$ \mathcal{E} Maryland	12 shou n and h is ma rauma	2	19a. Informant's Name/Relationship (7) Denise F. Boyd/ Sister						d Number or Ru			r Town, State, Z	lip Code)
Se Ce	s 1 and 3 health itam 27 other tr		20a. Method of Disposition		20b. F	36 Te Place of Disposi cemetery, cremi			ltimore, M	Date 212.34		cation - City or	Town, State
S in	@ ° = 5	١.	1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		State	tro Crema		ner place)	12-30-	-04	Cator	nsville, N	MD (II)
Baltim	permit. Pag Department Important: I any injury o		21. Signature of Funeral Source Licen	Palla	15	W	lylie I	unera	of Facility 1 Home 638			. Balto, B	MD 21217
			23a. Part 1. Enter the disease, or compensation, or heart failure. List only of immediate Cause (Final	lications hat one cause on e	caused the deat each line.							10	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to	1700C (or as a conseq	HCGW// juence of):	rea.	LMM.	nunidetik	riency	Syn	Korne	
	Examiner	ڀ	Sequentially list conditions,	b	(or as a conseq								
Ø	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	juence or):							
60,	icate be executed physician and s the burial-transit	I Exa	resulting in death) Last	Due to	(or as a conseq	uence of):							
68760,	icate phy: s the	edical	•	d									
D. Box	Hospital or Attending Physician: The law requires that the death certific 24 hours after death. Funaral Diractor: After this certificate has been signed by the attending pitely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live b	tcome of pregna pirth 2 Feta nant at time of d own	Ideath 3 □E	Ectopic pre Other <i>(spe</i>				2	3d. Date of deliving Month	very Day Year
, P.O.	res that the de signed by the a be detached f		Part II. Other significant conditions of	ntributing to d	eath but not res	ulting in the unc	derlying ca	use given	in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ords	w requires been sigr should be	ted by								10	Yes 2	No 3□Pro	bably 4 Unknown
Division of Vital Records,	The law ra cate has be page 2 sh	Completed								24a. Was autor perfo		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:	S	FD/O-1		Other	6. Place of Deat				
n of	ding Phys h. After this funeral di	on: To	27. Manger of Death	28a, Date		28b. Time of Injury	3 DO	c. Injury a Work?	4 Nursing Ho	ome 5∐ Resi 28d. Describe I		Other (Special occurred)	ify)
ision	Attendir death. ctor: Af y the fu	icatic	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗌 Ye	s 2 No	204 Leasting /	Carantan		10
Div	al or Attenos after death	Certification:	4 Homicide determined	buildi	of Injury - At hoing, etc. (Specif	y)	et, factory,	опісе		City or Tox		i Number or Hui	ral Route Number,
	To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by ti	edical	29a. Certifier (Check only one)	ner: On the b	a best of my kno asis of examina ner stated.	wledge, death o	occurred a estigation,	t the time, in my opin	date and place, ion, death occur	and due to the red at the time,	cause(s) date and	and manner as s place, and due t	stated. to the cause(s)
	To tha within 2 To the comple	Σ	29b. Signature and title of certifier	^			29c.	License n	number		29d. Date	signed (Month,	Day, Year)
	\		30. Name and address of person who co	U -	se of death (Item	23a) (Tuna D	rint)	845	000		10	129/04	
	121		Jewwo (Carrag	S	827 6	Jud.	in s	due le	Da/41	ner	i, MI	2/201
	Sta Registr	_	31. Date filed (Month Phi, Year) 2	105 32	legistrar's Signa	ture Agos	de		dre le				

		1 - For State Registrar	State of Maryla	and / Depa		ealth and f	Mental Hygie	_	4 4153	
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last, Catherine Eile 4a. Fecility Name (If not institution, give	en Berney street and number)		4b. City, Town, or		2. Date of Death Month December	Day Yeer 31, 2004 4c. County of Dee	3. Time of Death 1:40	
Funeral Director		Rockville Nursin 5. Social Security Number 6. Security Number 356-24-7621 Usual Residence of Decedent	X 7. Age (In y	rs. last birthday) 2 Yrs.	Rockvil If Under 1 Year Months Days	lf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Aug. 20,	Montgome 9. Bir 1932 I11	ry thplace (State or Foreign puntry) inois	
the Maryland 28e-f ehow	Director	10a. State 10b. County Maryland Montgomer	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. C						10d. Inside City Limit 1 ☐ Yes 2 📉 N	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funerai DI	12209 Kendall Str 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	eet 12. Was Decedent Ever in Amed Forces? 1 Yes 2 Woolf Yes, Give Year or Dates:		20902 Was Decedent of His If Yes, specify Cubar 1 Yes 2000	spanic Origin? (Sp., Mexican, Puerto	nited Sta 14 Race - Ame Black, Whi Specify: Wh	tes encan Indian, re, etc.		
	Completed	(Specify only highest grad	cation	(Give	ent's Usual Occupation kind of work done during most of working DO NOT use retired) istrative Assistant			16b. Kind of Business/Industry Federal Governme		
be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) John O'Connor 19a. Informant's Name/Relationship (Ty				18. Mother's Nam Josep	ne (First, Middle, Ma hine Mi	le, Maiden Sumame) Miknius		
is 1 and 2 soft Health avitem 27 is other trau		Jean M. Berney/Da 20a Method of Disposition 1 Burial 2 Cremation 3 - F	ughter	12209	Kendall	St., Whe	aton, Mar	yland 20 c. Location - City or	902 Town, State	
permit. Page Department of Important: If any injury or once.		*4 □ Donation / S □ Other (Specify,) 21. Signature of Juneral Jervice Licens	MQ087	Heaven-	Cemetery	of Facility Ro Inc., 30	bert A. P O West Mo	ilver Spr umphrey F ntgomery	ing, MD uneral Hom Avenue	
Physician /Medical Examiner		23a. Pafrt. Enter the disease, or compt shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the define cause on each line. Metastati Due to (or as a cons	c Lung	_	, such as cardiac	or respiratory arres		Approximate Interval Between Onset and Death	
ate be executed systeian and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
that the death certiticate I ed by the attending physi detached for use as the k	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
law requires that the as been signed by th 2 should be detache	e Completed by Ph	Part II. Other significant conditions con	cco use contribute to the cause of death? 2 \(\text{No} \) \(\frac{\frac{1}{3}}{2} \text{Probably} \) 4 \(\propto \text{Unknown} \)							
The ate h page		25. Was case referred to medical		-		26 Place of Door	24a. Was an autopsy performed 1 Yes 2 Check only one	d? prior to death?	topsy findings availab completion of cause of 2 No	
d is	atlon: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other	4 Nursing Ho	ome 5 Residence 28d. Describe how		city)	
F 5 F 5	Il Certification:	3 Suicide 4 Homicide 6 Could not be determined	City or Town, S							
To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29b. Signature and title of certifier	sician: To the best of my kiner: On the basis of exami and manner stated.	nation and/or in	vestigation, in my opi 29c. License D5191	nion, death occur number	red at the time, date	end place, and due Date signed (Monti ember 31,	n, Day, Year)	
Ó		30. Name and address of person who co Patricia Tomsko Nay	7, M.D., 1111	19 Rockv	Print) ville Pike	, G-100,	Rockvill	e, Maryla	nd 20852	
Sta Registi		31. Date filed (Month, Day, Year) JAN 0 3 20	32 Registrar's Sig	nature do	sole!					

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>		of Health of Death	1	R	leg. No. 20	04 41536
	Physici /Medi	cal	Decedent's Name (First, Middle, Last) Momchilo Bulatovich A. Facility Name (If not institution, give s			4b City To	wn, or Location	D	2. Date of Dea Month Decembe		
	Examir	ier	Manor Care of Bethe	esda		Bethe	sda			Montgo	mery
	Funeral Director		5. Social Security Number 176–52–3919 6. Sex	_	(In yrs. last birthday)	If Under 1 Y	Year If Under Pays Hours	Min	Date of Birth (Month, Day Ct. 13	, Year) 928 S	B. Birthplace (State or Foreign Country) erbia & Montenegr
	h the Maryland or 28a-f show o notified at	irector	10a. State 10b. County Maryland Montgome 1 10e. Street and Number		10c. City, Town or Lo Bethesda	cation	ode		1	l0g. Citizen of Wh	10d. Inside City Limits 1 □ Yes 2 No at Country?
9003	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I than 12 Is marked othar than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Evertiret must be notified at	d by Funeral Director	1 ☐ Never Married 2 🔼 Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ender Armed Forces? 1 ☐ Yes 2 ☒ Note of Yes, Give Year or Dates:		I∐Yes 25€	t of Hispanic Ori Cuban, Mexicar No Specify:		United States 14. Race - American Indian, Black, White, etc. Specify: White		
Maryland 21215-0036	filed within 72 P Hygiene. thar than "nating" int, the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give		occupation done during mos retired)	t of working		16b. Kind of Busin	_{ness/Industry} ive Service Co
yland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic evant, the Mes	3e	17. Father's Name (First, Middle, Last) Novica Bulatovic					er's Name (/ .ja Kl		Maiden Sumame)	
Baltimore, Mary	permit. Pages 1 and 2 sho Department of Health and Important: If itam 27 Is my any injury or other traums <u>once.</u>		19a. Informant's Name/Relationship (Ty) Dusan D. Vujcic/ Sc 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral (exceptions)	emoval from State	20b. Place of Dispo cemetery, com Park 1a Memorial	Doveto sition (Name of natory or other IWII Park . Name and A	on Circ1	e, Vi anuar 2005	enna, y y 4, rt A.	Pumphrev	22182
	Fnysician /Medical Examiner	16	resulting in death)	cations that caused to cause on each line Cholangi Due to (or as a	he death. Do not ente	er the mode of	rille, M	Cardiac or r	nd 2081 espiratory arro	50-2805 est,	Approximate Interval Between Onset and Death months
Box 68760,	The law requires that the death certificate be executed the been signed by the attending physician and bage 2 should be detached for use as the burial-transit	an/Medical Examine	230. Was decedent pregnant		consequence of): f pregnancy	Ectopic pregn	nancy			23d. Date o	,
P.O. B	that the deat ed by the att detached for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	4□Pregnant at ti 9□ Unknown	me of death 5	Other (specif	y)		220 Did tak	Month	Day Year
ords,	w requires to been signe should be c	eted by	Parti. Other significant conditions con	and thing to death but	not resolding in the di		e given in Part i.		1 □ Y€	es 2⊠No 3[□ Probably 4 □Unknown
Vital Record		e Completed	25. Was case referred to medical							y prio ned? dea 2 ☑ No 1 □	re autopsy findings available r to completion of cause of th? Yes 2 No
of	ling Phys I. After this Juneral di	To B	examiner?	ospital: 1 Inpatient 28a. Date of Injury (Month, Day	t 2 ER/Outpatient 28b. Time of Injury		O#	rsing Home		ence 6 DOther ((Specify)
Division	Diri	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, of	fice	28f	Location (Sti City or Town		or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	one)	cien: To the best of er: On the basis of e and manner state	my knowledge, death xamination and/or inv ed.	occurred at the estigation, in i	ne time, date an my opinion, deat	d place, and th occurred	I due to the ca at the time, da	luse(s) and manne ate and place, and	er as stated. I due to the cause(s)
	With with com	M	29b. Signature and title of certifier. 30. Name and address of person who cor	npleted cause of dea	ath (Item 23a) (Tvoe. F	D	cense number 55694			ecember	
	Sta	tė	Alok Mathur, M.D., 31. Date filed (Month, Day, Year)	4000 01ne	ey Laytons	ville	Road, 0	lney,	Maryla	nd 20832	
	Registr	-	IANI 0 9 2005	he and b	Course						

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** December 28, 2004 Basanti Bhattacharji 8:35 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 ☑ F 87 029-50-6456 Yrs Director July 19, 1917 India Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If them 27 is marked other than "retural", or items 23s or 28s-f show any Injury or other traumatic event. The Menters Events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director Maryland Montgomery Potomac 10e. Street end Number 10f. Zio Code 10g. Citizen of Whet Country? 8813 Tuckerman Lane 20854 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Asian-Indian Completed by 3 Nidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Hironmoyee Chatterji Jatindra Nath Mukherji 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Hena Bagchi/Daughter 8813 Tuckerman Lane, Potomac, Maryland 20854 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 31, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium 4 ☐ Donetion 5 ☐ Other (Specify) 2004 Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee Chase, M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical parkinger Examiner Due to (or as a consequence of): Physician/Medical Examiner After this certificeta has been signed by the ettending physician end funeral director, paga 2 should be detached for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as e consequença of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 ANO 1 ☐ Yes 2 ☐ No certificeta Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of within 24 hours aftar daath.

To the Funeral Director: After of completaly filled in by the funer 5 Pending 1. Naturel 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated. edicai 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified D0054566 12/28/04 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) , 1210 A sout roppa Road, Swit 230 Towsow, HD 2/286 Schika Bhogaville 32 Registrer's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

				State	Department of Health and M Certificate of Death	Mental Hygien	2004 41330
				Registrar 1. Decedent's Name (First, Middle, Last)	Octimoate of Boats	2. Date of Death	3. Time of Death
		Physici		Elizabeth R. Brown		December :	31,2004 4:50 A M
		/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
				Broadmead	Cockeysvill	e	Baltimore
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 17,1	9. Birthplace (State or Foreign Country)
		Director		213-40-7994 91 Usual Residence of Decedent	115.	July 1/,1	913 Baltimore
		/land		10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
		Many Many Milied	tor	MD Baltimore Cocke	ysville		1 ☐ Yes 2 🕅 No
		death with the Maryland ms 23a or 28a-f ahow rmust be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
		ath w	ral	13801 York Road	21030	anii Van anii	USA 14. Race - American Indian,
		itams itams	nue	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
	920	urs aff	by	3 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: White
	Maryland 21215-0036	within 72 hours after ene. than "natural", or its he Madical Exemin	ted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	ina 16b.	Kind of Business/Industry
	21	ithin Jen	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)		* **
	121	lled w Hygier ther th		17. Father's Name (First, Middle, Last)	Librarian 18 Mother's Nam	e (First, Middle, Maide	Library
	and	d be f antal h ed of	Be C	Alvis S. Rowe		abeth W. W	
	Z	shoul nd Me mark	J.	19a Informant's Name/Relationship (Type, Print) 19	o. Mailing Address (Street and Number or Rur		
		is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Mental and the Mental			Pastern Lane ue Bell, PA 19422		
٤	ore,	of He of He fitem r oth	1	20a Method of Disposition 20b. Place of			Location - City or Town, State
am	Ë	Pag ment ant: h		'4 □Donation 5 □Other (Specify)		005 F	alls Church, VA
4,50	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itams 23a or 28a-1 ahow any injury or other traumatic event, Ita M. ulcal Exponent must be notified at once.		21. Signature of Funeral Service Liansee Richael J. Flagle	22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road	of Dulane	y Valley, Inc. MD 21093
7	70	550		23a. Part1. The rithe disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			Approximate Interval Between
4		Physician		Immediate Cause (Final disease or condition	nt Lymphox	ทอ	Onset and Death
7	1	/Medical Examiner	ı	resulting in death) Due to (or as a consequence	of):		
31/04	8	LXammer	Ļ	Sequentially list conditions, b. Due to (or as a consequence	of)·		
3		rted nsit	nine	cause. Enter Underlying Cause (Disease or injury			
27	2	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last Due to (or as a consequence	of):		
,	1760	te be ysicie ne bur	cai	d			
C	89	certificat nding phy use as th	Med	IF FEMALE:			
row	Вох	death ce	Physician/Med	23b. Was decedent pregnant 1 Live birth 2 Fetal deat			23d. Date of delivery Month Day Year
27		he de the a	ysic	in the past 12 months 4 □ Pregnant at time of death 9 □ Unknown 9 □ Unknown	5 Other (specify)		
3	P.O.	requires that the een signed by th nould be detache		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
S.	Vital Records,	v requires been sign should be	ed by	breast concur		1 🗆 Yes	2 DNo 3 Probably 4 Unknown
(CO		Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
7	R	The I	E			performed?	? death?
2	/ita	ysician: The law is certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?		th (Check only one)	
zabeth	7	this a	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/O			6 ☐Other (Specify)
	ou c	fing F	Certification:	1 ☑Natural 5 ☐ Pending (Month, Day Year)	Time of lnjury at Work? M 1 Yes 2 No	28d. Describe how in	ijury occurred
W	Division	death death ctor: y the	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home.		28f. Location (Street	and Number or Rural Route Number.
	Div	after Dire	erti	4 Homicide building, etc. (Specify)		City or Town, Sta	ate)
		To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 111 ertifying Physician: To the best of my knowledge 211 Medical Examiner: On the basis of examination a and manner stated.			
_		o the	Mec	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
		r>=0		Fartona CARALLE	MA) D38393	2 1:	7/3//04
		b		30. Name and address of person who completed cause of death (Item 23a	(Type, Print)		11 Nan
			1	BARBARA CARROLLIM	0, 13801 YORK	. Ad,	Kaysill, ND
6		St	ate	31. Date liled (Month, Day, Year) 32. Registra's Signature	1. Coule	/	0 21030

			1 - For State Registrar	State of Maryland		irtment of H			ene 004	41539
	Physici		1. Decedent's Name (First, Middle, Last)	Evelyn Harvey	Brewe	er		2. Date of Death Month Dec. 30	Day Year	3. Time of Death 7:30 A.M
i	/Medic Examir		4a. Facility Name (If not institution, give s Genesis Elder Care			_	Locetion of Death	200. 30	4c. County of Dea	ith
	Funeral Director		5. Social Security Number 6. Sex 215-10-6264 Usual Residence of Decedent	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 25,	Year) 9. Bir Co 1910 T	thplace (State or Foreign ountry) 'exas
	e Maryland Se-f show	ctor	10a. State 10b. County Maryland Anne Aru		Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	al Director	10e. Street and Number 24 Truck House Roa	ad		10f. Zip Code 21146			g. Citizen of What Co Jnited Sta	•
5-0036	in 72 hours after death with the Maryland "netural", or Itams 23e or 28e-f show edical Ecaninet must be notitived at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	If	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto Specify:	cify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
0-61ZL	"nei	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. E	OO NOT use retired)	urina most of workii	ng 1	6b. Kind of Business	Industry
yland 2	ed la be	Be	17. Father's Name (First, Middle, Last) Lon	Hill	Harv	nemaker	18. Mother's Name			П
Mary	s 1 and 2 should be f Health and Mental fram 27 is marked other treumatic ev	10	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (Street a	nd Number or Rura	l Route Number,	Cubanks City or Town, State, 2	Henry Zip Code)
altimore, n	Pages 1 and nent of Health ent: If item 27 iry or other tr		Mrs. Elizabeth But 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pla cei	ace of Dispos metery, crem	Box 181 of sition (Name of satory or other place) Mem. Gd:	Dec.	ate 20	ary land 2 Oc. Location - City or Cimonium	
Dall	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service License	Brian	T. Ĉ	Name and Address 11Sho1m Fi 200 E. Pac	of Facility Ineral Se Ionia Roa	rvices o	f Dulaney	Valley, P.A
	/Medical Examiner	Examiner	23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	Do not ente	er the mode of dying	n, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death Adus
Box 68/6U,	nath certificate be executed attending physician and for use as the burial-transit	edlcal	in the past 12 months?	Due to (or as a conseque	cy death 3⊡i	Ectopic pregnancy			23d. Date of deli	ivery Day Year
٠	law requires that the death certific as been signed by the attending F 2 should be detached for use as	y Physiclan/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions cont	4 □ Pregnant at time of dea 9 □ Unknown tributing to death but not result		Other (specify) derlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
coras,	requires been sigr hould be	eted by				-				obably 4 Unknown
ital Rec	8 2 3	Completed						24a. Was an autopsy performe	prior to death?	itopsy findings available completion of cause of 2 No
310 10 1	ig Physician ter this certif neral directo	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Vatural 5 Pending		R/Outpatient 28b. Time of Injury	Otho	4 Wursing Hon		ce 6 □Other (Spec	cify)
DIVISION	To the Hospitel or Attanding Physician: The I within 2 Hours after death. To the Funaral Diractor: After this certificate he completely filled in by the funeral director, page	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	M 1 7	es 2□No	8f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	e Hospite 124 hours e Funeral tetely filled	edical C	(Check only 2 Medical Examina	ician: To the best of my knowler: On the basis of examination and manner stated.	on and/or inve	estigation, in my opi	nion, death occurre	d at the time, date	e and place, and due	to the cause(s)
	To the within to the comp	Me	29b. Signature and title of certifier	npleted cause of death (Item 2) 32. Registrar's Signatu	_ in	29c. License	number 5072	5 / 6	1. Date signed (Month	2004
	H		30. Name and address of person who con Jenniferkiedin	npleted cause of death (Item 2	23a) (Type, P	Print) 25 Hwy	M. Uar	sv.lle	MI) 6	21108
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 20	32. Agistrar's Signatu	* A	edis-		7		

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			giene 0 0 4	41540
	Physici /Medic Examir	cal	Decedent's Name (First, Middle Shirley Mae Bo: Aa. Facility Name (If not institution)	roughs		4b. City, Town, o	or Location of Dea	2. Date of Dea Month Decembe	Day Year	3. Time of Death
	Funeral Director		Joseph Richey 1 5. Social Security Number 214-24-7697		e (In yrs. last birthday 77 Yrs.		Baltimor 	8. Date of Birth	N/A 9. Birthpl Count	ace (State or Foreign try)
	th the Maryland or 28e-1 show	irector	Usual Residence of Decedent		10c. City, Town or L					Od. Inside City Limits 1. ☑ Ýes 2 □ No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel" or items 23e or 28e-1 show apply injury or other treumatic event, the Medical Exam are minst be notified at ance.	by Funeral Director	6309 Monika Pla 11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S. 13.	21207 Was Decedent of Hif Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	United State 14. Race - America Black, White, e Specify:	an Indian,
d 21215-0036	filed within 72 hoi Hygiene. ther then "nature int, the wedical	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 9 17. Father's Name (First, Middle,	nt's Education st grade completed) College (1-4or 5	(Give	odent's Usual Occup o kind of work done DO NOT use retire	during most of wo	orking	White 16b. Kind of Business/Ind Own Home	ustry
Maryland	should be and Mental is marked o	To Be	Quinton Ratcli 19a. Informant's Name/Relations	ffe Hillary	19b. Mail	ing Address (Street	Hilda M	ae Whitmo	,	Code)
Baltimore, M	ages 1 and 3 out of Health t: If Item 27 y or other tre		Leroy Hillary/I 20a. Method of Disposition 1 Burial 2 Fremation 4 Donation 5 Other (S	3 □Removal from State	20b. Place of Disponentery, cre		сө)	Date Dec 30	idge, MD 21	vn, State
Baltir	permit. P Departme Importen eny injur		21. Signature of Funeral Service							
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Records, P.	w requires that been signed b should be deta	by	Part II. Other significant condition	ns contributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to the	cause of death?
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ō	di S	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could of	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day gation not be	y Year) 28b. Time o	f 28c. Injur Wor M 1 🗆	er: 4 Nursing F	28d. Describe ho	nce 6 Se ther (<i>Specify</i>) w injury occurred	i useph Mich
DIA	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director. After th completely filled in by the funeral	edical Certif	(Check only 2 Medical	g Physician: To the best of Examiner: On the basis of	of my knowledge, deat examination and/or in	h occurred at the tir	ne, date and place	City or Town	use(s) and manner as stal	ted
•	To the within 2 To the comple	Med	29b. Signature and title of certifie	2 Jang manner sta	MD.	29c. Licens	e number	29	d. Date signed (Month, Da	ay, Year)
19	Sta Registr		30. Name and address of person D N V D L 1 31. Date filed (Month, Pay, Year)	who completed cause of de No X	_	Print) she Ave	, B.	Himose	Dec 28,	-1303.

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BOROW GATS

SHIRLEY MAE

			1 - For State Registrar	State of M	1aryland / D	epartmen Certificat			and Me	ental Hy	rgiene 0	04	41541
	Physic /Medi Examii	cal	Decedent's Name (First, Mid A LEC 4a. Facility Name (If not instituti NORTHWEST HOS	BUCKNER on, give street and number	r)			Location o	of Death	2. Date of Do Month	A 30 9	Year by of Death	3. Time of Death
	Funeral Director		5. Social Security Number 219-30-0952 Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	ige (In yrs. last birth	Months Months	1 Year Days	If Under 2 Hours		8. Date of Bi SEP - 23	th , 1935	9. Birthpla Count	ace (State or Foreign ry) MD
	he Maryland 28a-f show	ector	10a. State 10b. Coun MD BA	y LTIMORE	10c. City, Town	KESVILL							0d. Inside City Limits 1 ☐ Yes 2 🂢 No
	sath with t s 23s or 2 rust be n	Funeral Director	10e. Street and Number 4600 OLD COU			10f. Zip		2120			10g. Citizen of		USA
9600	72 hours after death with the Maryland natural', or itams 23a or 28a-f show disal Examinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 以 Ma 3 □ Widowed 4 □ Divorce	If Yes, Give Year or Dates	? INo	13. Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	Speci	ice - America ack, White, e fy:	
21215-0036	filed within 72 t Hygisns. Ither than "nati ant, the Medica	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12	est grade completed) College (1-4or	5+)	Decedent's Usua Give kind of wo life. DO NOT us AGER	al Occupa rk done o se retired,	ation furing most)	of working	g	16b. Kind of E		•
Maryland	should be filed and Mental Hygii is marked other aumatic evant, I	To Be (17. Father's Name (First, Middle ALBERT	, Last)		CKNER		MOL	LIE		, Maiden Suma		SIEGEL
	1 and 2 sh Health and Ism 27 is m		JOYCE BUCKNE		46		COUR		D -	PIKESV	er, City or Town	D 2120)8
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygisns. Important: if itsm 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Musical Evantinal must be notified at ance.		20a. Method of Disposition 1 🕅 Burial 2 Cremation 4 Donation 5 Other (21. Signature of Funeral Service)	Specify)	s of Facility	SOL	/2004 LEVIN	SON & B	IMORE, ROS.,	MD INC.			
	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, so conditions and the cause (Final disease or condition resulting in death) Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	s a consequence of	t enter the mod	e of dying	g, such as c					Approximate Interval Between Onset and Death
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rds, P	quires that n signed b	by	Part II. Dther significant condit	ions contributing to death I	but not resulting in t	ne underlying ca	ause give	n in Part I.			obacco use con Yes 2 \(\subseteq \text{No} \)	tribute to the	cause of death?
of Vital Record		e Completed	25. Was case referred to medic	al						1 ☐ Yes	osy rmed? 2 M No	prior to comp death?	sy findings available pletion of cause of
Division of Vit	Attending Physician: r death. sctor: After this certific by the funeral director.	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Notatural 5 Pend 2 Accident inves	Hospital: 1 Inpati 28a. Date of Injury Month, Date	ury 28b. Tin		8c. Injury Work	r. 4 🗆 Nurs	sing Home		one) dence 6 □Oth now injury occur		
Divis	ital or Atten rs aftsr deat al Diractor: led in by ths	Certification:	3 Suicide 6 Could 4 Homicide deten	nined 200. Flace of in	jury - At home, farm tc. (Specify)	, street, factory	, office		28	f. Location (5 City or Tov	Street and Numb vn, State)	oer or Rural F	Route Number,
	To tha Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	ledical	29a. Certifier 1 Certify (Check only one)	ng Physician: To the best I Exeminer: On the basis of and manner st	of examination and/o	death occurred a or investigation,	at the time in my op	e, date and inion, death	place, an occurred	d due to the at the time,	cause(s) and ma date and place,	anner as stat and due to th	ed. ne cause(s)
)	To T corr	×	29b. Signature and title of certification in the second se	2 - 00	ta m.o	E		410		7	29d. Date signe		h 2104
	\b\Sta		30. Name and address of person 31. Date filed (Month, Day, Year	JATIGZOPL	CENTER	rpe, Print)	OGIN NOA	us T	OWN	NEH-	TA) 211?		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			1 - For State Registrar 1. Decedent's Name (First, Middle, Las			rtificate of Dea	ath		g. No.	2 Tile and De all
	Physici /Medic	cal	GEORGE CARTER 4a. Facility Name (If not institution, give			4b. City, Town, or Loca	1	Month Ceembe	Day U	3. Time of Death
	Examir	ier				BALTIMORE			4c. County	or Death
	Funeral		UNION MEMORIAL HOS 5. Social Security Number 6. Se		n yrs. last birthday)			8. Date of Birth	1	9 Birthnlace (State or Foreign
	Funeral Director			©M 2□F 6	Vre		ours Min.	(Month, Day, 11–16–	^{Year)} 1940	Birthplace (State or Foreign Country) MD
	land ow		10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Many f sh	ţō	MD		BALTI	MORE				1 Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	What Country?
	h with		6630 MOONFLOWER CO	OURT		21214			USA	
36	d within 72 hours after death with the Maryland Jiene r then "natural", or Itama 23a or 28a-f show The Medical Exacites front the mofflied at	by Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give		Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Specexican, Puerto F	cify Yes or No- lican, etc.)		e - American Indian, ck, White, etc.
Ö	hour tural	d b	3 Widowed 4 Divorced	Year or Dates:	1 10 5					BLACK
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	filed within I Hygiene. other then	e Co	10 17. Father's Name (First, Middle, Last)		IR	UCK DRIVER	Mother's Name	(First, Middle, M	MD CU	
Maryland	o d to o	To Be	GEORGER CARTER				BESSIE		Ziden duman	
lar	2 sh and is m	0	19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street and N				
	s 1 and if Health item 27 other to		ADINA CARTER/WIFE			MOONFLOWER		ALTIMOR		21214
Baltimore,	nit. Pages 1 and 2 should antment of Health and Men ortent: If item 27 is marke injury or other traumatic		20a. Method of Disposition 1 Description 1 Description 3	Removal from State	•	natory or other place) IORIAL PARK	1-7-2	46.		City or Town, State MORE, MD
Balt	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licen:	. Mort		. Name and Address of F				SONS F.H., INC. MARYLAND 21217
68760,	/Medicale pe executed Examiner By physician and as the purial-transit	ledical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of): элэеqиэлсе об).	ic Gardi			- 13 p	
.O. Box 68	death certifi e attending id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetat death 3	Ectopic pregnancy Other (specify)			23d. Dat Moi	e of delivery nth Day Year
S, D	Se 75 90		Part tl. Other significant conditions co	ontributing to death but n	ot resulting in the un	nderlying cause given in F	Part I.			ibute to the cause of death? 3 Probably 4 Conknown
Ö	w require been sign	ete								
Vital Record	The ate h page	Completed						24a. Was an autopsy performe	ed? c	Vere autopsy findings available rior to completion of cause of leath? ☐ Yes 21 No
Ĭ	Physician: rthis certificatel al director,	Be o	25. Was case referred to medical examiner?	Hospital:		Other		Check onl one		
		-: To	1 Yes 2D No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 RER/Outpatien 28b. Time of	t 3□ DOA State: 4[28c. Injury at		e 5 🗆 Residen 3d. Describe how		
Division of	Attending I ir death. ector: After by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Ye	par) Injury	Work? M 1 ☐ Yes	2 🗆 No			
<u> </u>	tal or At	Certif	4 Homicide determined	building, etc. (S	Specify)			City or Town,	State)	er or Rural Route Number,
)	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phy 2 Medical Exam	vsician: To the best of m iner: On the basis of exa and manner stated	y knowledge, death amination and/or inv	occurred at the time, dai restigation, in my opinion	ite and place, ar , death occurred	d due to the cau d at the time, date	se(s) and ma e and place, a	nner as stated. nd due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. License num	ber	290	d. Date signed	(Month, Day, Year)
	•		Yandy Chlin	V.		D006	0560	DE	CEMR	ER 31.2004
	h		-	ompleted cause of death	(Item 23a) (Type, I	Print)		0		TIMORE, MD
				RPAL 20	1-109 13	ACK RIVE	r neu	e Ks.	BAL	TIMORE, MD
	Sta	te	31. Date filed (Month, DA: Near) 3	ZUUS 32. Pagistrar's	Signature	Dance				•

			1 - For Stata Registrar	State of Ma	•	epartment o		nd Mental H	ygiene	1. 1.151.2			
	Physici		1. Decedent's Name (First, Middle, La	EN (MOPE	=/*		2. Date of D Month	Death Day	Year 3. Time of Death Year M			
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	CONTER	- Privi	vn, or Location of I	Death	4c. County of	REDAE			
	Funeral Director		5. Social Security Number 6. S 213-36-0285 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. last birth			Min. 8. Date of E (Month, I June	13, 1940	Birthplace (State or Foreign Country) Maryland			
	Maryland -f ehow lied at	tor	10a. State 10b. County Maryland Baltimo	ore	10c. City, Town Baltir					10d. Inside City Limits 1 ☐ Yes 2 ▼No			
	with the 3a or 28a 1 be notii	i Direc	10e. Street and Number 304 Suter Road Ag	ot. A		10f. Zip Co	de 21228		10g. Citizen of W	hat Country? ted States			
36	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f ehow the Meulcal Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1! If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify	of Hispanic Origin Cuban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)		- American Indian, , White, etc. White			
21215-0036	within 72 hou iene. 'than "nature i'e Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	- (Decedent's Usual O Give kind of work d life. DO NOT use r	lone during most o etired)	of working		ore City epartment			
	2 should be filed within and Mental Hygiene. 7 is marked other than "raumatic event, ILAME.	To Be C	17. Father's Name (First, Middle, Last Allen H. Clopeir			111011911	18. Mother's	s Name (First, Midd isy Karne:	le, Maiden Sumame				
, Maryland	1 and 2 shou Health and M tam 27 is mai		19a. Informant's Name/Relationship (Burnette Clopein	*1 '					ber, City or Town, S timore, M	State, Zip Code) aryland 21228			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, Item Medical Examinat must be notified at one.		20a. Method of Disposition 1	(y)	cemetery		f For. 12		Owings M Funeral He	City or Town, State Mills, Maryland Ome, Inc. aryland 21229			
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as b. Due to (or as c.	a consequence of	ot enter the mode of the control of	dying, such as ca	ardiac or respiratory		Approximate Interval Between			
Box 68760,	death certificate be executed e attending physician and nd for use as the burial-transit	dlcal	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcome	a consequence of	3 □Ectopic pregn			23d. Date	of delivery			
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Records	a law req has beer e 2 shou	Completed by	TO PREVIOU	S CAR	Ditaley	CATHY S	icensa.	24a. Wa	s an 24b. W	B Probably 4 Monknown are autopsy findings available ior to completion of cause of earth?			
Division of Vital Records,	or Attending Physician: ifier death. Diractor: After this certification by the funeral director, in	Certification: To Be Co	25. Was case referred to medical examiner? 1	10 Ope Place of Ini	y Year) 28b. Tin		Other: 4 Nursi	28d. Describe	vione) sidence 6 Other how injury occurre				
_	To the Hospital within 24 hours a To tha Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
4	Sta Registr		30. Name and address of person who 31. Date filed (Month, Day, Year)	mplyted cause of d	wand me	Type, Print)	(950) NONCE RANDA	invest H Us toni		(Month, Day, Year) BILLY > CFD (FILL) CFD (FILL) AND 21133			
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			For State Registrar		State	of Maryla	•	irtment of F tificate of		nd Men		ene 20	04	41544
			Decedent's Name	(First, Middle,	Last)						ate of Death	1	V	3. Time of Death
	Physicia		Audrev	I	٠. (Cook				De	wonth	Day 200	Year 04	10:05 a ^M
	/Medic Examin		4a. Facility Name (If			umber)		4b. City, Town, o	r Location of			4c. County		
			7305 Dun	wall Ct	. Apt.	. A		Dundall					timore	
	Funeral		5. Social Security Nu		5. Sex 1 □ M 2 🙀 F		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours		Date of Birth Month, Day,			lace (State or Foreign try)
	Director		217-26-48 Usual Residence of		-X	1	74			Oct	taber 1,	,1930	M) <u>.</u>
	land ow		10a. State	10b. County		10c. (City, Town or Lo	cation					1	0d. Inside City Limits
	Mary I-f sh	tor	MD.	Baltin	ore		Dunda.	lk						1 ☐ Yes 2X No
	h the	Director	10e. Street and Num	nber				10f. Zip Code			10	g. Citizen of	What Coun	try?
	11 wit		7305 Dunw	all Cou		. A.			222			USA		
	tams	Funeral	11. Marital Status		Armed F	cedent Ever in orces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Puerto Ricar	Yes or No- n, etc.)		ce - Americ ck, White,	
36	hours after death with the Maryland turel', or Items 23e or 28e-1 show al Examinational Legisland at	by F	1 Never Marrie 3 Widowed		d 1Yes If Yes, G Year or	2 No live Dates:		1 ☐ Yes 2 📉 No	Specify:			Specif	y: Whi	.te
21215-0036	d within 72 hours after death with the Marylan jiene. r than "natural", or Itams 23a or 28a-1 show the Madical Eraninat Le ruilliad at	ed		15. Decedent's	Education		16a. Dece	tent's Usual Occup	pation	-4	1	6b. Kind of B	lusiness/Inc	dustry
215	within 72 ene. then "net	Completed	(Special Special Speci	<i>,</i> , , , , , , , , , , , , , , , , , ,	grade completed	(1-4or 5+)	life.	kind of work done OO NOT use retired	d) most (or working				
		Corr	12 years				Hou	sewife					V Home	<u> </u>
pu	o dat	Be	17. Father's Name (ast)							faiden Sumai	ne)	
Z	should I nd Meni narke umatic	T _o	William		- (Toron Bright)		40h Maili	ng Address (Street		Marie		City or Tour	State Zie	Code
Maryland	12 sho h and 7 is mu trauma		19a. Informant's Na					South Mar					2122	
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		Paul Coo. 20a. Method of Disp			son 20b		sition (Name of natory or other place	- 1	Date	- 2	Oc. Location		
JOI	m O >-		1 🔀 Burial 2 🛭 1 4 🗖 Donation	☐Cremation	3 □Removal from	n State		ll Memori	1 -	Decemb 31, 20		Middle	Rive	r MD
Baltimore,	그 된 원 등		21. Signature of Fu		* .	- 1		Name and Addre						L, HD.
ñ	Depa Depa Impo any It		1 th	EAR	XXX.	int Ro	ad, Du	indlak,	MD.	21222				
			23a. Part1 Enter th	ne disease, or o	omplications that nly one cause on	caused the de each line.	ath. Do not ent	er the mode of dyir	ng, such as c	ardiac or res	spiratory arre	st,		Approximate Interval Between Onset and Death
П	Physician		Immediate Cause (I		a.	metall	atic 1	Rectal	Carco	7			1	Lyon
	/Medical Examiner		resulting in death)	1	Due to	o (or as a cons	equence of):							0
į.		70	Sequentially list con	nditions,	b	o (or as a sone	equianes of j:							
	nted 1 ansit	Examine	if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events	injury										
oʻ.	exectan and and rial-tra		resulting in death) L		Due to	o (or as a cons	equence of):							
58760,	cate be executed physician and the burial-transit	dicai			d									
_		Med	IF FEMALE:	-						-				
Вох	death certifil e attending p id for use as	lan/	23b. Was decedent in the past 12		1 Live	utcome of preg	etal death 3	Ectopic pregnancy	у			7	ate of delive onth	ry Day Year
0	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□ Unk	gnant at time o known	rdeath 5L	Other (specify) _						
۵.	de de		Part II. Other signifi	icant conditio	s contributing to	death but not r	esulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	acco use con	tribute to th	e cause of death?
ds,	uires n sign	d by									1 🗌 Ye	s 2 X No	3 Prob	ably 4 □Unknown
Record	s been s shout	ojete									24a. Was an			psy findings available inpletion of cause of
B	The law ate has page 2:	Completed									perform	ed?	death?	
Vital		Be C	25. Was case referr	red to medical						of Death (Ch	eck only one	9)	-	
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 🔀				☐ ER/Outpatier		4 LI Nur	-		nce 6 🗆 Oth		9
	Ing	lon:	27. Manner of Death 1 X Natural	5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury	Wo			Describe no	w injury occur	rred	
Division	or Attending after death. Director: After in by the fune	2 Accident 2 Accident 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Street a									eet and Num	ber or Rura	I Route Number,	
ρ	or Attend after death Director:	ertii	4 Homicide	determin	buil	lding, etc. (Spe	city)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 '	City or Town,	State)		
	spita hours meral y fillec		29a. Certifier	1 X Certifying	Physician: To t	he best of my k	nowledge, deat	occurred at the til	me, date and	place, and	due to the ca	use(s) and m	anner as st	ated.
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	one)		xaminer: On the and ma	basis of exami anner stated.	nation and/or in	vestigation, in my o		n occurred at				
	with To t	Σ	29b. Signature and	title of certifier	. 0,	, D		29c. Licens			29	d. Date signe	ed (Month, .	Uay, Year)
			* '/ı.	inte	(1) Xbay	11 pky	lucin		9714		1	2/21/	04	
	K		30. Name and addre		/ho completed de ノムアレル	Use of death (II J48V	tem 23a) (Type,	Print)	Alten	- AV	e R	distance-	mel	7-17-24
	Sta	te	31. Date filed (Mont	·		Begistrar's Sig	nature		, ,	110	; 12	, - , , , , , , , , ,	, 7	-, /
	Regist		C.	JAN 0 3	2005	Dolux	gnature B. A	artie						
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			Please	Type or Print in				•	•		
			1 For Stata	State of Maryla				d Mental Hy	giene	1 1 5-0 1 5-0	
			Registrar 1. Decedent's Name (First, Middle, Last,	1	Ce	rtilicate	of Death	la Data of Da	Reg. N&. U U 4	41545	
	Physici /Medi		Anne V. Chew						Day Year	4 105 p M	
	Examir	er	4a. Facility Name (If not institution, give	street and number)	Lol	4b. City, To	own, or Location of De	ath /	4c. County of Dea	ath /	
			5. Social Security Number 6. Sec	7 Analyn yrs	(UCC . last birthday)	If Under 1	400KC Year If Under 24 H	rs & Poto of Bir	None		
	Funeral Director			м 2፼F 80	Yrs.		Days Hours M	in. B. Date of Bir (Month, Da Dec. 1	ly, Year)	inthplace (State or Foreign Country) Cyland	
	Aaryland f show	ō	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	the 28a	Director	Maryland Anne Ar 10e. Street and Number	rundel A	nnapo	10f. Zip C	ode		10g. Citizen of What C	1	
	h with	I Di	4 Kirby Lane				1401		USA	, out it y	
	deatl	Funeral	***************************************	12. Was Decedent Ever in t Armed Forces?		Was Deceder	nt of Hispanic Origin?	(Specify Yes or No	- 14. Race - Am		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinal must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Waidowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 Tes, specify	Cuban, Mexican, Pu	erto Hican, etc.)	Black, Wh	ite, etc. Black	
S O	72 ho natu	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual (Decupation done during most of w	vorking.	16b. Kind of Business	s/Industry	
12	vithin ne. han	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)		Cafeteria		
2	iled v Hygie thar t	ပိ	11th 17. Father's Name (First, Middle, Last)		Coc	ok	10 Math and N	(First Add del	Elementar Maiden Sumame)	ry School	
au	d be antal	o Be	Olice Brown	2				tie Dig			
Maryland	shoul nd Me mark	To	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (S			er, City or Town, State,	Zin Code)	
Š	nd 2 alth a 27 Is		Saundra Sanders	(Daughter)					dena, Ca.		
Baltimore,	of Hei		20a. Method of Disposition	20b.	Place of Dispo	sition (Name	of	Date	20c. Location - City or	Town, State	
Ĕ	Page nent c ant: If		†∰Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Ma	ryland metery	d Vete	eran 12/	30/04	Crownsvil	le, Md.	
at	permit. Departr Importu any inji		21. Signature of Funeral Service License			. Name and	Address of Facility				
Ш	20599		23a. Part1. Enter the disease, or compli	se M00483	Wr 82	n. Ree 21 Wes	ese & Son	ıs Mortu napolis	ary, P.A.	101	
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consecutive to (or a))).	ge 1 quence of):	BREAS NE ER	1 1	1CER		Approximate Interval Between Onset and Death	
8760,	eath certificate be executed attending physician and for use as the burial-transit	u u u u u u u u u u u u u u u u u u u									
Box 68	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	by Physician/Medi	in the past 12 months?	3c. If yes, outcome of pregn 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3	Ectopic pregi			23d. Date of de Month	livery Day Year	
o.	the d by the	ysi	1 □ Yes 2 □ No 9 □ Unknown	9☐Unknown		J Other (Speci	·97				
Records, P.	uires that the dei signed by the a Id be detached f		Part II. Dther significant conditions con	tributing to death but not res	sulting in the ur	nderlying caus	se given in Part I.		obacco use contribute to	./	
00	w require been si should I	lete						24a. Was	245 14/22		
		Completed						autop perfor	sy prior to	utopsy findings available completion of cause of	
Vita	sicia certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ospital:	ISD/O	-500	Oth	ath (Check only or			
ō	g Phy er this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		Injury at Work?		ence 6 Other (Spe	cify)	
0	ttanding death. ctor: Aft y the fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No				
Division of	al or Attanos after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	eet, factory, o	ffice	28f. Location (S City or Tow	itreet and Number or Run, State)	ural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical	29a. Certifier (Chack only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowar: On the basis of examination and manner stated.	wledge, death ition and/or inv	occurred at t restigation, in	he time, date and place my opinion, death occ	e, and due to the curred at the time, o	ause(s) and manner as late and place, and due	s stated. s to the cause(s)	
	To the transfer of the transfe	Σ	29b. Signature and title of certifier			29c. L	cense number	2	29d. Date signed (Mont	h, Day, Year)	
	/		Numin Dasc	HANCHALSIN	Cott. M. I	> 8	4537	1	2/22/04		
	り			mpleted cause of death (Iter			and Gre	neral	Hospita	el	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2005	32. Registrar's Signa	ature						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 0350 Olivia 2004 Docember amara 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Daltimore Baltimore Medical If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 1□ M 20 F Days Months December 19,2004 Yrs. Maryland None Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No MD BAltiMORE 10g. Citizen of What Country? 10e. Street and Number USA . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 NNo If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: BIACH Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ITEVIN DAY 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHATFORD AVE 20b. Place of Disposition (Name of cemetery, crematory or other place) BAlte FATHER DAY ITEVIN 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 12/27/04 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 21. Signature of Funeral Service Licens 69 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1-2 days Chorioamnioitis Due to (or as e consequence of): Tremature rupture of in utero membranes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2⊻No 1 ☐ Yes 2 1 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Examiner sata has been signed by the attending physician and page 2 should be datached for use as the burial-trensit or Attending Physician: The law raquiras thet tha death certificeta be executed Division of Vital Records, P.O. Box 68760, cartificata diractor, this within 24 hours after deeth.

To the Funerel Director: After this completely filled in by the funerel of

Physician/Medical Examiner

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Completed

Be

Certification: To

Cal

Physician

/Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Director

pamit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ehoweny Injury or other treumstic event, the Medical Examinal must be notified at

Baltimore, Maryland 21215-0036

3 Suicide 4 Homicide

29a. Certifier

25. Was case referred to medical 1 Yes 2 No 27. Menner of Death 1 ☑ Natural 2 Accident

5 Pending investigation 6 Could not be determined Date of Injury (Month, Dey Year) 28b. Time of

28c. Injury at Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of cartifier

29c. License number AU417 6435 DIS 791 29d. Date signed (Month. Dav. Year)

Carember 19

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

and manner stated.

M

Baltimore Medical Center Mercy

State Registrar

31. Date filed (Month, Day, Year) JAN 0 3 2005



			For Stete Registrer	State of N	Maryland / Depa Cea	artment of rtificate o			giene ()	04	41547
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death
ı	*Physici /Medic		Dora W. Detschla	q				Month Decembe	Day er 23.	Year 2004	9:10 P M
	Examir	er	4a. Facility Name (If not institution, giv	e street and numbe	ar)	4b. City, Towr	n, or Location of Dea			ty of Death	
4.	. A.	: F	Pickersgill			(1)-4-4	Towson			imore	
ŀ	Funeral Director			00 M 2 2 √F	Age (In yrs. last birthday) 89 Yrs.	If Under 1 Ye Months Day		n. (Month, Day	r, Year)	9. Birthpl Coun	lace (State or Foreign htry)
			216-36-0741 Usual Residence of Decedent		0.9			Jan 25,	1915	MD	
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
	e Ma	ctor	MD Baltimo	re	Parkville	е					1 ☐ Yes 2 No
	ith th or 28	Director	10e. Street and Number			10f. Zip Code	θ		10g. Citizen o	What Coun	itry?
	s 23£	ra	8626 Richmond Ave			21234			United		
	hours after death with the Maryland tural', or Itams 23s or 28e-f show at Exartment percellified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder	s?	Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Ra	ace - America ack, White, e	
39	urs afte	by F	3 Widowed 4 Divorced	1 ☐ Yes 2√2 If Yes, Give Year or Dates		1□Yes ≱ZIN	No Specify:		Spec	ify:	
9	72 hours "natural", ulcal Exe	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usual Occ	cupation		16b. Kind of	White Business/Ind	
218	d within 72 ho liene. r then "natur I're Mculical.	Completed	(Specify only highest gra	College (1-4o	life.	kind of work do DO NOT use ret	ne during most of w ired)		Own Ho		,
2		Con	8		Homen	naker					
gu	ba d o d	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Suma	ımə)	
3	should ba ind Mental s markad c umetic eve	To	Julius Schueler				Frieda	Woerwag			
Maryland 21215-0036	2 is is		19a. Informant's Name/Relationship (Rural Route Number			,
	gas 1 and 1 of Health If item 27 or other tr		Mrs. Charlotte Re 20a. Method of Disposition	ek/Friend	20b. Place of Dispo	sition (Name of		Baltimo:	re, MD 20c. Location		
Baltimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from Stat	cemetery, cren	natory or other p	olace)	Dec 31		,	
Ħ			21. Signature of Euneral Service/Licer	1500	Chesapea	ke Crem		2004	Beltsv.	ille,	MD
B	permit. Departn Importe any inju		1 In Hal	ell 1	wo200	Crematio	on and Fu	neral Alt	ernati	ves	
Г			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the death. Do not enti-			res Drive acorrespiratory arm		17.7	Approximate
D	Pnysician		Immediate Cause (Final disease or condition	LA.	L'omic	(AV	didmy	Lapath	9		Onset and Death
	/Medical		resulting in death)	aDue to (or a	as a consequence of):	C/. /	7	1 1	/		Jens
	Examiner		Sequentially list conditions,	b				U			·
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					1	
	and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or a	is a consequence of):						
8760,	cate ba executed physician and the burial-transit	dical E		4	,						
9	tificate ig phy as the	edic		, d.				_			
Вох	eath certif attending for use a	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		T			23d. Da	ate of deliver	ry
	ne deat the att	sicla	in the past 1 m ofths? 1 ☐ Yes 2 X No			Ectopic pregnar Other (specify)			M	onth (Day Year
P.0	that the deatt ad by the atte detached for	Physiclan/Me	9 🗆 Unknown								
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions	ontributing to death		nderlying cause	given in Part I.		11		e cause of death?
orc	requi	eted	Millian Fr	·				1 🗆 Ye	s 2 X No	3∐ Proba	ably 4 □Unknown
Vital Records,	has the	Completed	AUTTIC STE	noses				24a. Was a autops	V	prior to com	sy findings available apletion of cause of
<u> </u>								perform	No No	death? 1 ☐ Yes 2	2□ No
Ę	ysicien: The I is certificate ha director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:				ath Check on on			
of	Phys ar this aral di	T. To	27. Manner of Death	1 ☐ Inpat	jury 28b. Time of	28c. Ini	iury at	Home 5 Reside			
on	nding tth. :: Afte e fund	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	lay Year) Injury	W	lork? □Yes 2□No		,,		
Division of	Atternation of the party of the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	280. Place of Ir	njury - At home, farm, streetc. (Specify)	eet, factory, offic	е	28f. Location (Str		ber or Rural .	Route Number,
۵	itel or rs afte al Dii ed in	Cerl		building, e	stc. (Specify)			City or Town	, Siate)		
	or the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certification the funeral director, completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bes niner: On the basis and manner s	t of my knowledge, death of examination and/or inv stated.	occurred at the restigation, in my	time, date and plac opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and mate and place,	anner as sta and due to t	ted. the cause(s)
	To the within To the comple	M	29b. Signature and title of certifier	1 1			nse number		9d. Date signe		ay, Year)
)	/1		Ill Hothung	Kily	; un	100	17997	1	recon	Mer 2	4,2004
	4		30. Name and address of verson who d	completed cause of	death (Item 23a) (Type, F	Print)	CI	Salto m	, -	2 . 4	
	,		W. A. Reley	Giby	16 6701 /	1. Chon	Les St. 1.	salto. M.	d 210	×0×	
	Sta Registr		31. Date filed (Month, JA Near) 3	2005 ^{32. Regist}	trar's Signature	and in					

			For Stata Registrar	State of	f Marylan		epartm C <i>ertific</i>				Mental Hy				51.2
			Registrar 1. Decedent's Name (First, Midd	le, Last)		~	Jeruno	ale of	Dea	11/1	2. Date of De	Reg. No	F 0 0 3	3. Tim	e of Death
П	Physicia /Medic		Clifton	Sunic		D	orr	7			Decen	ber	35 20		45рм
	Examin		4a. Facility Name (If not institution baltımore Kena	n, give street and nur	mber) F+	end	4b. C	ity, Town, o	r Locat	tion of Death		-	c. County of De	ath	•
			are center					palt		400PE					
П	Funeral Director		5. Social Security Number 219–58–1356	6. Sex 1 6 2 M 2 ☐ F	7. Age (In yrs.	54 Y	Mont	der 1 Year hs Days	Hou	nder 24 Hrs. urs Min.	8. Date of Bi (Month, D. Dec 14	rth ay, Year, 19	9. B	irthplace (Sta Country))	te or Foreign
	ס		Usual Residence of Decedent								DCC 14	, 10	750 112		
	anylan show	_	10a. State 10b. Count				or Location								e City Limits
	the Mi	ecto	MD Harfo	ord	Abe	erde		Zip Code				100 Ci	itizen of What		65 2 (110
	with 3a or	Funeral Director	2056 Park Beac	n Drive				.001					ted Sta	,	
	death	nera	11. Marital Status		edent Ever in U	.S.	13. Was Di	cedent of H	lispanio	c Origin? (Sp xican, Puerto	ecify Yes or No		14. Race - Ar	nerican Indiar	١,
36	or Ite	y Fu	1 Never Married 2 Ma	rried 1- Yes	2 No		_	s 212 No	Spe		nican, etc.)		Black, Wi	IIIO, OIC.	
Ö	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show iteal Examirer must be mattled at	ed by	3 Widowed 4 vivorce	d Year or Da	ates:69-72		Decedent's I		ation			16b k	Wh :		
75	within 72 ene. than "ne	Completed		est grade completed) College (1	-4or 5+)	1	Give kind of life. DO NO	work done	durina i	most of work	ing		identia	-	sing
21	filed with Hygiene other tha	Com	11			Bui	lder								
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ira M.	Be	17. Father's Name (First, Middle Clifton David							Mother's Nam rnice	e (First, Middle Wills	, Maidei	n Sumame)		
Ĭ	shoutd nd Men s marke umatic	2	19a. Informant's Name/Relation			19b.	Mailing Add	ess (Street				per. City	or Town, State	. Zip Code)	
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. If eath and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a or 28e-1 show item 27 is marked other than "neturel" or Items and it a Woolfeat Examiner must be notified at		Kathy Smith/Si			1	-	•					MD 210	, , , , , ,	
ore,	of Hei of Hei fitem r othe		20a. Method of Disposition	3 □ Bomoval from	1 6	lace of l	Disposition (Name of or other plac	ce)		Date Dec 29	20c. L	ocation - City	or Town, State	
Baltimore,	Pag tment tent: I		`4 □Donation 5 □ Other (Specify)		esap	eake			7 2	2004		tsville	, MD	
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tra once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and F 8717 Green Past											atives altimo	ce, MD	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	r complications that controls one cause on e	aused the deat ach line.	h. Do no	ot enter the	node of dyin	ng, such	h as cardiac	or respiratory a	arrest,			mate Between nd Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a END				isis a	OF	LIVE	R			ONE	YEAR
	Examiner			Due to (or as a conseq	uence of):								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of	·):								
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
38760,	ficate be executed physician and s the burial-transit	ai E	, and a second s	Due 10 (or as a conseq	uence o).								
687	ificate g phys as the	edicai		d											
Вох	leath certifi attending l I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		3∏Ectop	c pregnancy	,				23d. Date of d		
O. E	requires that the death certif een signed by the attending hould be detached for use at	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of d		5 Other		-				Month	Day	Year
P.O.	that the de led by the detached		Part II. Other significant condit	ions contributing to de	ath but not res	ulting in	the underlyi	ig cause giv	en in P	art I.	23e. Did	tobacco	use contribute	to the cause	of death?
Records,	requires that Leen signed should be det	ed by	POLY SUBS	TANCE A	BUSE						1 🗆	Yes 2	ў хио з□।	Probably 4	□Unknown
900	lav 2 :	Completed									24a. Was		24b. Were	autopsy findin	gs available
E 3	Te pa	Con									perfe 1 Tes	ormed?	death	, _	
Vit.	Physician: Th r this certific te ral director, pag	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ₹ No	Hospital:				DOA Oth			h (Check only				
10	ding Phys h. After this funeral di	-	27. Manner of Death	28a. Date (of Injury	ER/Outp	me of	28c. Injun	4 🔎		me 5 □ Hesi 28d. Describe		6 □Other (Sp iny occurred	ecity)	-
Sior	ttendin death. ctor: Aft / the fun	atlo	2 - 7 100100111	tigation	h, Day Year)		ury M			2 🗆 No					
Division of Vital	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification;	3 Suicide 6 Could 4 Homicide deter	mined 200. Flace	of Injury - At hong, etc. (Specif	ome, farr y)	n, street, fac	tory, office			28f. Location (City or To		nd Number or I e)	Rural Route N	lumber,
	pspita hours unerel y filled		29a. Certifier 1 Certify	ing Physician: To the	best of my kno	wledge,	death occur	ed at the tin	ne, date	te and place,	and due to the	cause(s	and manner	as stated.	
	the Ho in 24 the Fu	Medical	one)	I Examiner: On the ba and mann	asis of examina ner stated.	tion and	or investiga				red at the time,				
1	To To Con	2	29b. Signature and title of certifi	of an	. 14.1) 、		29c. Licens	e numb YA	Ser ()		29d. Da	ite signed (Moi	nth, Day, Yea	NE
,	X	- 9	3g. Name and address of person	who eempleted caus	e of death (Item	(n 23a) (T	yge, Print)	01.	(1.	0		yece D	it.	J1, J	VUT
	19		Aurora C	lan P	1D 3	900	Lock	Kav	en	Boule	evard	₽00	MB	212	81
	Sta		31. Date filed (Month, Day, Yea	3 2005	egistrar's Signa د کاران	iture	Sport								
	Registr	ar	JAN 0	0 2003		- 15	•								

		•	1 - For State Registrar		State of	of Mai	ryland	-	artmen				lental Hy	giene	200	L	41549
			Decedent's Name (First, Mid	dle, Last)	,								2. Date of De	ath Day	, ,	eer	3. Time of Death
н	Physici: /Medic		Huretta J	. I	Davis								Month 12-22			991	9:25 PM
	Examin		4a. Facility Name (If not instituti	on, give s	street and no	umber)			4b. City,	Town, or	Location of	of Death		4c.	County of	Death	
			10401 Grosve							thes					Montg		
	Funeral		5. Social Security Number	6. Sex	x]M 2 y[]√ F	7. Age		ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	y, Year)		. Birthp	lace (State or Foreign
	Director		413-03-1110 Usual Residence of Decedent		2121			115.					10-29	-191	13		TN
	and and	ŀ	10a. State 10b. Coun	ty			10c. City	, Town or Lo	ocation							1	0d. Inside City Limits
	Mary fet	ō	MD Mont	tgome	∍ r v		Be	thesd	а								1 ¥Yes 2 □ No
	the	rec	10e. Street and Number	- 80	<u></u> j			cheba	10f. Zip	Code				10g. Cit	zen of Wha	at Cour	ntry?
	3a o	Funeral Director	10401 Grosve	nor F	Place						2085	2		US	SA		
	death	ner	11. Marital Status		12. Was Dec		er in U.	S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race -		
စ္	after or ite	F	1 Never Married 2 Married			2 1 No)		1 ☐ Yes :		Specify:		riidani, etc./		Black, Specific T		
8	ural',	d by	3 ₩idowed 4 Divorce	∌d	Year or I	Dates:				- MI	Openny.				Specify: V	vnit	:e
<u>.</u>	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f ehow te Moules Exercites main the notified at	Completed	15. Decedo (Specify only high)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	l Occupa	ation during mos	t of worki	ng	16b. Ki	nd of Busin	ness/Ind	dustry
12	withir noe. than	dm	Elementary/Secondary (0-12)	College ((1-4or 5+)		eache		,				School	C ₇	retom
2 2	Hygie ther ther	ပိ	12 17. Father's Name (First, Middl	e, Last)					cache		18. Mothe	r's Name	(First, Middle,			_ <i>O</i> y	300111
an	d be antai red o	To Be	Ross Joines										Ervin		·		
Maryland 21215-0036	shoul nd Ma mari	F	19a. Informant's Name/Relatio	nship (Ty	rpe, Print)			19b. Mailin	ng Address	(Street a			I Route Numbe	er, City o	r Town, Sta	ate, Zip	Code)
Š	nd 2 alth a 27 is		Dr. Nancy J.	Davi	is D	augh	ter	10	0401	Gros	venor	P1a	ce Beth	esda	MD		20852
ē,	tem of Hea	i	20a. Method of Disposition				20b. P	lace of Dispo	osition (Nan	ne of ther place	e)		Date	20c. Lc	cation - Cit	y or To	wn, State
E	Page nent c int: if		1			n State	l	ven H		•		12/2	8/04	Ma	disor	vi1	le TN
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Importent: if Item 27 is marked other than "natural", or items 23a or 28a-1 show amy figury or other treumatic event, It is Modical Examinating the notified at anone.		21. Sign there of Funeral Service	e Lice	00/2/	11.		1 2	2. Name an	d Addres	s of Facilit	Cro -		C			
m —	825 29		Mant C	1/	Tel	Xa	170		933 G	ist .	raı α Ave S	ilve	mation r Spri n	serv	2091	.0	
П			23a Part1. Enter the disease, shock, or heart failure. L	or compli st only or	ications that ne cause on	caused t	he death	. Do not ent	ter the mod	e of dying	g, such as	cardiac o	or respiratory a	rest,			Approximate Interval Between Onset and Death
3	nysician /Medical		Immediate Cause (Final disease or condition		a	Sep	sis										Oriset and Death
-	/Medical Examiner		resulting in death)		Due to	•		uence of):	Ema ata					C.	me		
į,		_	Sequentially list conditions,	t	b. — Due to	or as a		sion]	rracti	ire			12	1	0001	_	
Π	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	≺	540 (Ane		20.100 0/2			C		1	345	/		
_,	al-tra	Examiner	that initiated events resulting in death) Last	C	c. Due to	o (or as a	consequ	uence of):			-	1	0150	THE STREET		-	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	call			d	Pol	ymya	lgia	Rheur	natio	ca	1					
9	tificating physics that the	6	Le service														
ŏ	eath certific attending pi	an/N	IF FEMALE: 23b. Was decedent pregnant	2	23c. If yes, ou 1 ☐ Live	utcome o			Ectopic pr	egnancy				1	23d. Date o	f delive	,
O.	e dea the at ned fo	Physician/M	in the past 12 months? 1 Yes 2 XNo		4∐Preg 9∐Unki	gnant at ti nown	me of de		Other (sp						Month		Day Year
<u>Ч</u>	res that the deligned by the a	Phy	9 ☐ Unknown Part II. Other significant cond	itions on	atributing to	doath but	not race	ulting in the u	adachina o		on in Bort I		23a Did to	obacco u	se contribu	ita to th	e cause of death?
ŝ	signe d be d	by	Patt II. Other significant cond	MONS COI	inibuting to t	ueatii but	1101 1650	atting in the d	indenying c	auso give	an mir anti.						ably 4 Unknown
Records,	w requir been si should I	etec									**					200	
3ec	has l ge 2 s	Completed											24a. Was autor perfo		prio dea	r to cor	osy findings available npletion of cause of
a	n: Th licate r, pag		00.14										1 Yes	2 X No			2□ No
⋚	Physicien: r this certifica ral director,	o Be	25. Was case referred to medi examiner?	_	Hospital:	Inpatien		ER/Outpatier	nt 3 DC	Dthe			n <i>(Check only c</i> me 5 Resid		C Cobor /	Canaiá	4)
O	ding Physicien: The interpretation of After this certificate had funeral director, page	n: To	1 ☐ Yes 2 🔀 No 27. Manner of Death		28a. Date (Mo			28b. Time o		8c. Injury Work			28d. Describe I			Specify	7
ion	Attending r death. ector: After by the fune	atlo	1 XNatural 5 ☐ Pen- 2 ☐ Accident inve	ding stigation	(MOI	nin, Day	rear)	Injury	М		Yes 2	No					
Division of Vital	I or Attencatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not be rmined	28e. Plac	ce of Injur	y - At ho	me, farm, sti	reet, factory	, office		- 1	28f. Location (S City or Tox			or Rura	l Route Number,
Ö	rs after or sell or sell blir	Cer			4												
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filted in by	edical	29a. Certifier 1 X Certification (Check only 2 Medicone)	ing Phys al Exami	ner: On the	ne best of basis of e nner state	examinat	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my of	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manne place, and	er as st I due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certi	lier					290	. License	number				e signed (A		
)	•		> +IM		mo					MD0	05979	4		Ι	ec. 2	23,	2004
	_0		30. Name and address of person	on who co	ompleted car	use of dea	ath (Item	23a) (Type,	Print)								
	V		Le Le Luu M	.D.;	1201	Seve	n Lo	cks R	d. #1	11;	Rockv	ille	, MD 20	852			
	Sta Registi		31. Date filed (Month, Pay Yea	032	2005 32.	Higistran	's Signa	ture!	Josefi								

			State of Maryland / Department of Portificate of Maryland / Department of Certificate of Ce			CUILL	1.1550
			1. Decedent's Name (First, Middle, Last)		2. Date of Dea	eg. No.	3. Time of Death
	Physici	an			Month	Day Year	5. Time of Death
	/Medic		MADELINE EMMA DORN 4a. Facility Name (If not institution, give street and number) 4b. City, Tow	vn, or Location of Death	DEC. 3	31,2004 4c. County of Death	D JUOFIV
	Examin	er		LTIMORE		N/A	1
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		8. Date of Birth	Q Rinth	hplace (State or Foreign
г	Funeral Director		213-01-0520 1 M 2X F 93 Yrs. Months Da	ays Hours Min.	(Month, Day, DEC.	18,1911 M	aryland
			Usual Residence of Decedent				
	how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f s	cto	MD. N/A BALTIMORE				1XX Yes 2 ☐ No
	or 2	Director	10e. Street and Number 10f. Zip Co		1	0g. Citizen of What Co	
	s 23s			21214	Was as No.	U.S.A.	
	er de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	of Hispanic Origin? (Spec Cuban, Mexican, Puerto R	ican, etc.)	Black, White	
36	hours after death with the Maryland tural, or items 23a or 28a-f show al Examiliatinual be ricilified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ Yes videowed 4 ☐ Divorced Year or Dates:	No Specify:		Specify: WH	HITE
21215-0036	thin 72 hours after death with the Marylan e an "natural", or items 23a or 28a-1 show Medical Examinations the notified at		15. Decedent's Education 16a. Decedent's Usual O			16b. Kind of Business/I	Industry
215	within 73 ene. than "n	pie	(Specify only highest grade completed) (Give kind of work d life. DO NOT use n	lone during most of working etired)	9		
21	M et a	Completed	8 SALESPERS	SON		HUTZLER'	S
	be filed tal Hygi d other event.	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, I	Maiden Sumame)	
<u>yla</u>	should be and Menta marked umatic ev	2	JOHN SIBISKI	FRIEDA			
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic			treet and Number or Rural			
	l and fealth m 27 her t		DIANE BOEMMEL/DAUGHTER 905 S. CON 20a. Method of Disposition (Name of Di	KLING STRI		LTO. MD.	
ŏ	0 0	1 3	Burial 2 Cremation 3 Removal from State	r place)			
Baltimore,	permit. Pag Department Important: i any injury c		_	OF JESUS ddress of Facility	1/6/05	BALTIMOR	E, MARYLAN
Ba	permit. Pag Department Important: I any injury o		LILLY 8	ZEILER IN CONKLING	ኒር. Eu	NERAL HOM	1E 21224
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one caus, on each ine.				Approximate Interval Between
	Pnysician		Immediate Cause (Final	c. andi	NUCas	ula Ai	On et and Death Zn
	/Medical		disease or condition resulting in death) a. Due to or is a consection ence of):	1		01014	
	Examiner		Sequentially list conditions, b. F. Sequentially list conditions,	w			5 /chy
	pe is	iner	if any, leading to immediate Cause. Enter Underlying	110,0	70		7 years
	death certificate be executed attending physicien and afor use as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	10000	10-		(floor
8760,	be e. sicien buria						U
687	ficate physics the l	edical	d				
Вох	death certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
ă	death a atte d for	Physician/Me	in the past 12 months? 1 Ves 2 MNo 4 Pregnant at time of death 5 Other (specific			Month	Day Year
0		hys	9 ☐ Unknown				
s, P	requires that the been signed by th hould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did to	bacco use contribute to	. ^
ord	been sight	ted			1 🗆 Y	es 2 No 3 Pro	obably 4 Unknown
Record	aw 2 s	Completed			24a. Was a	24b. Were au	topsy findings available completion of cause of
	The ate h	Com			perform	meg? death?	2 🗆 No
Vital	iclan: certific rector,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only of	18)	
of \	Physician: this certific ral director,	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Hom	/ \		zify)
	De je	lon	1 Natural 5 Pending (Month, Day Year) Injury	Injury at 28 Work? 1 ☐ Yes 2 ☐ No	od. Describe in	ow injury occurred	
Sic	Attending ir death. ector: After by the fune	ical	3 Suicide 6 Could not be One Place of Laive. At home form street feature of		8f. Location (S	treet and Number or Ru	ıral Route Number.
Division	i Ditto	Certification:	4 Homicide determined building, etc. (Specify)		City or Town		
	Hospital 24 hours a Funeral (tely filled		29a. Certifiler (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in	he time, date and place, as	nd due to the c	ause(s) and manner as	stated.
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	one) and manner stated			29d. Date; signed (Month	
š.,	wit To	<	29b. Signature and title of certifier	icense number	33	12/2/1/	n X
	110		30. Name and ad rest of person who ampleted cause of death (tiem 23a) (Type, Pyhr)	0,00	1	7771	
1	10		9. 9 have 261 5. 121/1/04	1-1. MAT	(SIM	1.47 3	11224
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Snature	342			
	Regist	rar	JAN 0 3 2005 June 2				

			1 - For State of Maryland / De Registrar	epartment of Health and Men Certificate of Death	tal Hygien 0 0 4	41551
	Dis. 1.1.1		Decedent's Name (First, Middle, Last)		Date of Death	3. Time of Death
	Physic: /Medi		MARLENE		Month Day Year	
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	eath
			Sinai Hospital of Baltimore	Baltimore		IA
	Funeral		5. Social Security Number 6. Sex 1 M 2 DF 7. Age (In yrs. last birth.	Months Days Hours Min. (Date of Birth 9. E Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	0	EC07, 1932 M	ARYLAND
	death with the Maryland ms 23a or 28a-f show rr-ust be notified at		10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
	a-f sl	Funeral Director	MARYLAND NIA	BALTIMORE (TITY	1⊠.Yes 2□No
	or 28	ire	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?
	23a d	al	3514 ELLAMONT ROAD	21215	45	A.
	r dea	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 		merican Indian,
36	hours after urai', or Ite	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Specify: 1	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It's Mydical Execution is traumatic event.	be pe	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. D	and the Hard Country of th	X.	LACK
15	in 72	Completed	(Specify only highest grade completed) ((ecedent's Usual Occupation live kind of work done during most of working fe. DO NOT use retired)	16b. Kind of Busines	ss/Industry
2121	with iene r than	E	Elementary/Secondary (0-12) College (1-4or 5+)	SUPERVISOR	FENERAL	GOVERNMENT
	Hyg other	Be C	17. Father's Name (First, Middle, Last)		st, Middle, Maiden Sumame)	. O O VERCHINEUT
Maryland	ald be fenta rked ric ev	To B	JOSEPH A. FORD	SR. CARRIE	ELIZABETH	MARSHAII
ary	and N s ma	-	19a. Informant's Name/Relationship (Type, Print)	ailing Address (Street and Number or Rural Rou	ute Number, City or Town, State	, Zip Code)
	and 2 saith n 27 i		DORISE, FORD (SISTER) 30	5/4 ELLAMONTRD sposition (Name of Date	BALTO, L	1021215
Baltimore,	permit, Pages 1 and Department of Health Important: If item 27 any injury or other troops.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of D cometery,	sposition (Name of Date crematory or other place)	20c. Location - City	or Town, State
<u>Ë</u>	nit, Pag vartment ortant: I injury o		'4 Donation 5 Other (Specify)	ATHEDRAL 01-05	-05 BALTIHOP	E MARWAIN
alt	permit, Pag Department Important: I any injury c		21. Signature of Funeral Service Licensee	22. Name and Address of Facility, BR	OWN JR. Fu	NERAL Home
_	205 2 3		MON ON	2140 N. FULTON F	AVE, BALTO, A	4D. 21217
П			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or res	piratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ocardial Infarcti	C #9	Onset and Death
	/Medical Examiner		disease or condition resulting in death) a Due to (or as a consequence of):	,		
		<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of:	pertension		
	ted rsit	Examiner	rany, leading to Immediate Due to (or as a consequence on cause. Enfor Underlying Cause (Disease or injury that initiated events c.			
	xecul and al-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E				
687	ificate g phy as the	edic	0.			
Вох	nding use a	M/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_	23d. Date of d	elivery
	death e atte	icia	in the past 12 months? 1 Ves 2 No 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	Month	Day Year
P.0	ttthe by th tache	Physician/Me	9 Unknown			
	signed by det	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
ord	w require been si should I	pe			1 ☐ Yes 2 ☐ No 3 ☐ F	Probably 4 Minknown
Records,	e law r has be je 2 sh	pie			24a. Was an 24b. Were a	autopsy findings available
		Completed		1	autopsy prior to death? Yes 2 No 1 Yes	completion of cause of
Vital	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Che		
of \	ys dis	2	1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		5 ☐ Residence 6 ☐ Other (Sp	ecify)
	ding Ph h. After th funeral	inol :	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju	y Work?	Describe how injury occurred	
Sic	r Attendii er death. rector: A by the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
Division	or A after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	ocation (Street and Number or F lity or Town, State)	Rural Route Number,
_	spital ours eral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	and the converse of at the time date and the converse of the c		
	24 hos 24 hos Fun etely	Medical	(Check only one) Check only one Check one C	r investigation, in my opinion, death occurred at	ue to the cause(s) and manner a the time, date and place, and du	as stated. ue to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Me	and mainst stated.	29c. License number	29d. Date signed (Mon	nth, Day, Year)
	Λ		29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Tyl D - Patrick M (C-Inley M.D., 2401) 31. Date filed (Month, Day, Year) JAN 03 2005	MEREUUOS	No. 5	-77 2m4
	/h		30. Name and address of person who completed cause of death (Item 23a) (Ty,	De. Print)	VECEMBER	0 / 2007
			D- Patrick McC-inlew M.D. 2401	West Beliedere Ave.	Baltimore n	10 21215
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		7,100	
	Registr	ar	JAN 0 3 2000			

			1 - State Registrar	te of Maryland / Dep Ce	partment of Fertificate of			ene2004	41552
П	Physici	an	Decedent's Name (First, Middle, Last)	C -1.			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Lucia VI	. For ay ce	11 01 7		DECEMBE		1055 P M
	Examin	er	4a. Facility Name (If not institution, give street a			r Location of Death		4c. County of Death	1
	Funeral		1327 HIGHRIDGE DRIVE 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)		If Under 24 Hrs.	8. Date of Birth (Month, Day,	CARROLL 9. Birth	nplace (State or Foreign
	Director		467568723 10M2	79 Yrs.	Months Days	Hours Min.	Molpith, Day,		intry) IE. ITALY
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or	ocation				10d. Inside City Limits
	Maryli f sho	or	MD CARROLL	WESTMINI					1 Tyes 2 No
	r 28a-	rec	10e. Street and Number	WIBITINI	10f. Zip Code		10	g. Citizen of What Cor	
	th with	alD	1327 HIGHRIDGE DRIVE		2115	8		USA	
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examinat must be notified at	Funeral Director	11. Marital Status 12. Wa	s Decedent Ever in U.S. ned Forces? Yes XXNo	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by Fu	If Y	Yes ŽŽ No es, Give ar or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify: WHI	
21215-0036	2 hour	ed t	15. Decedent's Education	16a. Dec	edent's Usual Occup	pation	1	6b. Kind of Business/I	
215	thin 73	ple	(Specify only highest grade comp Elementary/Secondary (0-12) Co	leted) (Giv	re kind of work done DO NOT use retired	during most of work	ing		,
2	ygien ygien yarth t. rhe	Completed	12		ACCOUNTAN			SERVICE	
land	uld be fill fental H rked oth tic evan	To Be	17. Father's Name (First, Middle, Last) RAFFELE MELIS			18. Mother's Name ANGELA		aiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be notified at once.		19a. Informant's Name/Relationship (Type, Pri. PAULA BOSLEY	DAUGHTER 19b. Mai	ling Address (Street	and Number or Run	al Route Number, WESTMINI	City or Town, State, Z.	ip Code) 1158
Jre,	of Hearitan		20a. Method of Disposition	20b. Place of Disposer competery, cr	position (Name of ematory or other place		Date 2	0c. Location - City or 1	fown, State
Ē	Page nent c ant: If ury or		1XXBurial 2 ☐ Cremation 3 ☐ Remova '4 ☐ Donation 5 ☐ Other (Specify)	I from State	VEN CEMET		9.04	GLEN BURNI	E. MD
Baltimore,	Departicular Depar		21. Signature of Funeral Service Liamsee RELLY GREGORY FINK	P F	22. Name and Addre	ss of Facility AL HOME,	P.A.		
			23a. Pant. Enter the disease or complications shock, or heart failure. List only one caus	that caused the death. Do not e	26 CRAIN I	HWY SW GL ng, such as cardiac	EN BURNII or respiratory arres	E, MD 2106	Approximate
	Physician	87 IU	Immediate Cause (Final disease or condition	on each line.	A 0 200	CAM P			Interval Between Onset and Death
	/Medical		resulting in death)	due to (or as a comequence o):	UWIN	1000			3426
	Examiner	L	Sequentially list conditions, b.	6060					1200
	ed isit	Examiner	Sequentially list conditions, I any, Isaamg to immediate cause. Enter Underlying Cause (Disease or injury	lue to (or as a consequence of): -					0
	xecut and al-trar	xan	that initiated events c.	ue to (or as a consequence of):					
8760,	cate be executed physician and the burial-transit								
9	tificati ig phy as the	ledic	U		17817474				
Вох	th cer rendin	an/N	23b. Was decedent pregnant	es, outcome of pregnancy Live birth 2 Fetal death 3	□Ectopic pregnancy	,		23d. Date of deliv	,
O. E.	es that the death certific igned by the attending p be detached for use as	Physiclan/Medlcai	1 Ves 2 No		Other (specify)			Month	Day Year
٥.	that the		Part II. Other significant conditions contributing	a to death but not resulting in the	underlying cause give	en in Part I	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	ed by	Disportes	.				,	bably 4 Unknown
ecc	as be	Completed					24a. Was an autopsy		opsy findings available ompletion of cause of
<u>س</u>	The ate h	Con					_ performe	d? death? ZNo 1 ☐ Yes	2□ No
Vita	Attanding Physician: r death. ector: After this certifice by the funeral director, I	Be	25. Was case referred to medical examiner?		0.1		(Check only one)		
	Phys this ral dir	Ţ.	TU Yes 214NO	1 ☐ Inpatient 2 ☐ ER/Outpatie Date of Injury 28b. Time		4 Nursing Ho	me 5 siden 28d. Describe how	ce 6 Other (Speci	fy)
Division of	ding th. After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Worl	k? Yes 2 □ No	Edd. Describe non	injury occurred	
Visi	Attand ar death. ector: A by the fa	ifica	a Could not be	Place of Injury - At home, farm, s	treet, factory, office			et and Number or Rur	al Route Number,
Ö	tal or A	Certification;	4 Homicide	building, etc. (Specify)			City or Town,	State)	
	To the Hospitel or Attending Physicien: The tawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examiner: Or	To the best of my knowledge, dea the basis of examination and/or i d manner stated.	ith occurred at the time nvestigation, in my of	ne, date and place, a pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner as se and place, and due t	stated. to the cause(s)
	To tha within 2. To tha complet	Me	29b. Signature and title of certifier		29c. License	e number	290	d. Date signed (Month,	Day, Year)
	^		Charle in	. Human on	1/10	9105	1	71271	64
	17		30 ame and address of person who complete	d cause of death (Item a) (Type	, Print)	0.1.2	. 0 -		. 7.
			Chanles in 1	tr 12364 how	74 16	- my	Colm [Journ, W	Not mus h
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	E CONTRACT				
			JHU 0 2 500	- 1	. *				

			For State Registrar	State of	Marylan				lealth and N Death	Mental Hy	giene	004	41553
			1. Decedent's Name (First, Middle, La	ast)						2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medio		WILLIAM P.	FARRELL			,			Decemb	er 30	, 2004	8:31pm M
	Examir	ner	4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location of Death		4c. C	ounty of Death	ı
			Greater Baltimo				Tows		If Under 24 Hrs.	O Data of Bi		timore	-1
	Funeral Director			Sex 1 7 1 1 2 1 2 1 F 7	7. Age (In yrs. 77	Yrs.	Months		Hours Min.	8. Date of Bi (Month, Di 5/11/	ay, Year)	9. Birth Col MAVT	place (State or Foreign intry) TIELD, PA
			Usual Residence of Decedent							3/11/	1921	IIAII	TELD, IA
	Maryland -f show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	a-f.s	ctor	FL VOLUSI	iA		PT.	ORAN	GE					XXYes 2 □ No
	with the Maryland a or 28a-f show Le netified	Director	10e. Street and Number				10f. Zip				10g. Citize	on of What Cou	intry?
ر	death with the ms 23e or 28e Fraust be neti	rail	941 D WINDRIDGE					321				USA	
2	er de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 Married	12. Was Deced	ces?	.S. 13. \	Was Deced If Yes, spec	dent of H cify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No Rican, etc.)	o- 14	. Race - Amer Black, White	
38 38	irs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give)		1 🗆 Yes	2 XVO	Specify:		s	pecify: WH]	TE
	2 hou		15. Decedent's E	ducation		16a. Deced	dent's Usua	al Occup	ation		16b. Kind	of Business/li	ndustry
215	within 7 ene. than "n	ple	(Specify only highest gi Elementary/Secondary (0-12)	College (1-	4or 5+)	life. I			during most of world)	King			
`- ⊰ ⊼	~	Completed	12				SUPE	RVIS			1	IL COME	PANY
- pu	tal Hid off	Be	17. Father's Name (First, Middle, Las WILLIAM P. FARF						18. Mother's Nam	ne <i>(Fir</i> st, <i>Middle</i> A BURLA		umame)	
=======================================	nould be is Mental narked o	ပို	19a, Informant's Name/Relationship			405 14 18		(0)	and Number or Ru				
Ø B	d 2 sho th and 7 is mu treum		JOAN FARRELL	(турө, Рппт)		1	-				-		DA 32127
G.	s 1 and 2 should be filed if Health and Mental Hyg Item 27 is marked othe other treumetic event,		20a. Method of Disposition			lace of Dispo	sition (Nar	ne of	1	Date		tion - City or T	
Z P	permit. Pages Department of t Importent: If its any injury or of		XZBurial 2 ☐ Cremation 3X 4 ☐ Donation 5 ☐ Other (Spec		tate	emetery, crer LVARY	-		1/5/	2005	JOHN	SON CIT	Y. NY
江潭	artme corter injur	H	21. Signat Service Lice		0) 22	2. Name ar	d Addres	ss of Facility FI				
Ä	permi Depa Impo any is		KELLY CREGO	FINK #	M01148	/			HIGHWAY			MD 21	
			23a. Part . Enter the disease, or con shock, or heart failure) List only	nplications that ce	used the deatl	h. Do not ent	er the mod	e of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 1	neum	ion!	α						Onset and Death
	/Medical Examiner		resulting in death)		or as a conseq								
	LXdiffile	Ļ	Sequentially list conditions,	b	or as a conseq	uanaa aft:							
- 5	bed is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D d	1 as a conseq	uerice orj.							
~	The law requires that the death certificate be executed tite has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Exan ine	that initiated events resulting in death) Last	cDue to (c	or as a conseq	uence of):							
760,	ysicia e bur	dicail	(d									
89	ntifical ng phy as th	0	IC CENAL C.										
Вох	eath certific attending p i for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outc 1 ☐ Live bir	ome of pregna th 2 Feta		Ectopic pr	egnancy			23	d. Date of deliv	very Day Year
E	it the dea by the at tached fo	sici	1 Yes 2 No	4□Pregna 9□Unkno	int at time of down	eath 5□	Other (sp	ecify)				MOUNT	Day Teal
P.O.	hat thed by detacl	Ph	Part II. Other significant conditions	contributing to dea	ath but not res	ultina in the u	nderlvina c	ause div	en in Part I.	23e. Did 1	tobacco use	contribute to	the cause of death?
ds,	uires that signed t d be det	d by	•	3		3	, , ,			10	Yes 2	No 3∏Pro	bably 4 Dunknown
, o	w requir been si should	lete								24a. Was	an	24h Were aut	onsy findings available
Re	The law ate has page 2	Completed								auto perfe	psy ormed?	death?	opsy findings available ompletion of cause of
tal	icien: Th certificate ector, paç	a)	25. Was case referred to medical						26. Place of Dea	1 ☐ Yes		1 🗆 Yes	2U No
⋛	ysicionis cer direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 lin	patient 2	ER/Outpatien	nt 3 🗆 DC	Oth	er: 4 ☐ Nursing H			Other (Speci	fy)
Ö	ding Phone		27. Manner of Death 1. □ Natural 5 □ Pending	28a. Date of	f Injury n, Day Year)	28b. Time of	2	8c. Injun	/ at	28d. Describe			
io	Attending Physicien: sr death. ector: After this certifice by the funeral director, p	satic	2 ☐ Accident investigation	on			М	1 🗆	Yes 2 □ No				
Division of Vital Records,	or Attendater death Director: Director: Jin by the f	Certification:	3 Suicide 6 Could not determined	4 280. Place	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory	, office		28f. Location (City or To	Street and I wn, State)	Number or Rur	al Route Number,
	Hospitel or At 4 hours after of Funerel Directely filled in by	Ce	29a. Certifier 1 Certifying P	hygician: To the	hast of my kee	udodoo dooth		at the tie	ne, date and place,	and due to the	201100(0) 01	nd manner on a	ntated.
	24 hc 24 hc Fun etely	edicai	(Check only 2 Medical Exa	miner: On the ba	sis of examina	tion and/or in	vestigation	, in my o	pinion, death occur	red at the time,	date and pl	lace, and due I	to the cause(s)
_	To the Hospitel within 24 hours a To the Funerel C completely filled	Me	29b. Signature and title of certifier						e number		29d. Date s	signed (Month,	Day, Year)
	1.1		Dicam. 11.	Selaske-	61.12	2	4	00	C434	57	15	131/	04
	ONI		30. Name and address of person who	completed cause	of death (Item	1 23a) (Type,	Print)	,	, r 1 -		/	, ,	212C4
_	-1		Brian) Isch	vier- po	6569	N. A.	Galley!	1.00	57, 5	is 601	Ba	1dine	-c MB
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	2005	gistrar's Signa	(Ale	_						

James E. Flaherty Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-8452 1- For Unpend Item 23a,27,28a-f per me (839, 1-25-05, tas Certificate of Death Reg. No. AKG Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30, <u>2004</u> **Physician** December 1:20 P James Everett Flaherty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 210 Holiday Court Room 104 Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2 ☐ F 39 119-58-2134 Director Apr. 27,1965 NY Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 7 is marked other then "naturet", or items 23e or 28a-f sho traumatic event, the Medical Exam an interious by riviting a MD Anne Arundel Severna Park 1 ☐ Yes 2 XINo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21146 USA 730 Trenton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. ☐Yes 2 Yes, Give 1 ☐ Never Married 2X Married 2 X No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physical Ed. Teaching Asst. Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sue Stephenson Frederick H. Flaherty, III 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ent: If item 27 is i 730 Trenton Avenue, Severna Park, MD 21146 Lori K. Flaherty/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 3, 2005 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō Baltimore, MD permit. Page Department of Importent: If eny injury or once. Metro Crematory ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Narcotic and Cocaine Intoxication /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760. Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 🗌 Yes 2 12 106 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Be director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: $4 \square$ Nursing Home 5 \square Residence 6 \square Other (Specify) at Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 💢 Yes 2 No 28a. Date of Injury Found, Day Year) 12-30-04 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending 5 Pending investigation Found 1 Natural 1 ☐ Yes 2 X No after death. 2 Accident 1:07 6X Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found in hotel room 28f. Location (Street and Number of Rural Route Number, City or Town, State) 210 Holiday Ct. 4 Homicide Annapolis, Md within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

Morae

JAN 0 3 2005

30. Name and address of person who HLM ISMMS

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORGU

O.C.M.E.

111 Penn Street, Baltimore, Maryland

December 31, 2004

			For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of F			giene 2001	4 41555
	Dhysisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	ath Day Yee	3. Time of Death
	Physici /Medio		Vicente Ortells					Decemb	er 26, 200	04 2120 M
	Examin	er	4a. Facility Name (If not institution, g				r Location of Dea	th	4c. County of De	
	Euparal		Shady Grove Adv 5. Social Security Number 6.		Spital Ag <i>e (In yrs. l</i> as <i>t birthd</i> ay	Rockvil	If Under 24 Hr		Montgome 9. E	Birthplace (State or Foreign
	Funeral Director		577-66-2385	1፟ X M 2□F	70 Yrs.	Months Days	Hours Min	Sept.	ν, _{Υθαι)} 11, 1934 S _I	Country)
	pu 🛾		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Aaryla f shor	ō		m 0 1477	Rockvill					1 N Yes 2 No
	the h	rect	Maryland Montgo: 10e. Street and Number	nery	ROCKVIII	10f. Zip Code			10g. Citizen of What	Country?
	36 of	Ö	1402 Thornden Ro	ad		20851			United Sta	ates
	ems ?	ıner	11. Marital Status	12. Was Deceder Armed Force		Was Decedent of H	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ar Black, W	merican Indian,
36	within 72 hours after death with the Maryland ene. then "netural", or items 23e or 28e-1 show its Medical Exerti her must be malified at	by Funeral Director	1 ☐ Nøver Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates		1□Yes 2₺No			Specific	
9	tural	edb	15. Decedent's I		16a, Deca	edent's Usual Occur	pation		16b. Kind of Busine	White ss/Industry
215	hin 72 9. "ng Mediu	Completed	(Specify only highest g Elementary/Secondary (0-12)		(Give	e kind of work done DO NOT use retire	during most of we	orking		,
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Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Las					ım <i>e (First, Middle,</i>		
<u>~</u>	d Mer narke netic	5	Vicente Carda 19a. Informant's Name/Relationship		10h Mail	ing Address /Street		es Martin	r, City or Town, State	Zia Codo)
Ma	id 2 si Ith an 27 is r treur		Angelina G. Fust						, Maryland	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumetic event. It is Medical Examination at the maillies of DDGe.		20a. Method of Disposition			osition (Name of matory or other pla		Date 2,	20c. Location - City	
altimore,	Page nent o int: If iry or		1 ☐ Burial 2 🖾 Cremation 3 `4 ☐ Conation 5 ☐ Other (Spec		Montgome Cremator	ry ium, Inc.	200	-	Bethesda,	Maryland
ä	rmit. spartm porte ly inju		21. Signatu of Funeral Service Lig	nsee		2 Name and Addre	es of Facility R	hert A.	Pumphrey 1	Funeral Home/
<u> </u>	90 E 2 9		Muil !	sury.					ontgomery -2805	
Г			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	nplications that caus y one cause on each	ed the death. Do not er line.	iter the mode of dyli	ng, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ u	dyplastic S	yndrome				6 Weeks
П	Examiner			Due to (or a	as a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a consequence of):					
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	C						1
8760,	oe execian a	EX	resulting in death) Last	Due to (or a	as a consequence of);					
387	ficate be executed physician and is the burial-transit	dicai		d						VEN EN
Вох 6	death certifica attending plant for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of c	delivery
m	that the death cer ed by the attendin detached for use	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of death 5	□Ectopic pregnanc □ Other (specify) _	4		Month	Day Year
Р. О.	at the by th	hys	9 🗆 Unknown	9∐ Unknown				-		
Š,	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/Med	Part II. Other significant conditions			underlying cause giv	en in Part I.	1		to the cause of death? Probably 4 XUnknown
oro	requi	eted	Gastrointestina	T breeding	5			.50		
3ec	has t ge 2 s	mpi	Pancytopenia					24a. Was a autop: perfor	sy prior t	autopsy findings available o completion of cause of ?
ā	icien: Th certificate rector, pag	e Co	25. Was case referred to medical				OS Place of Do		2 □ No 1 □ Y	
\leq	ysicie is cert directe	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1X Inpa	itient 2 ER/Outpatie	nt 3□ DOA Ott	oc		ence 6 □Other (Sp	pecify)
Division of Vital Records,	ng Phys ter this neral dii		27. Manner of Death 1 Natural 5 Pending	28a. Date of Ir (Month, L		of 28c Inju	y at		ow injury occurred	
Sio	eath. or: Al	catle	2 Accident investigati	on		M 1	Yes 2 □ No			
Σ	l or Attending after death. Director: After in by the funer	Certification:	4 Homicide determine	200. FIACO OF	Injury - At home, farm, s etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 14 Certifying F	hvsician: To the be	st of my knowledge, dea	th occurred at the ti	me date and plac	e, and due to the c	ause(s) and manner	as stated
	To the Hospita within 24 hours To the Funerel completely filled	edicai	(Check only 2 Medical Extone)	ıminer: On the basis and manner	of examination and/or is	vestigation, in my	pinion, death occ	urred at the time, o	late and place, and d	ue to the cause(s)
	To the vithin To the comp	Me	29b. Signature and title of certifier	00	On the second	29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
)	,		House	all f	LO MI	D382	62	-	December 2	27, 2004
	7	1	30. Name and address of person who	•						
)		A. Mendhiratta,	M.D. 240	01 Research	Boulevar	d, Suite	300, Ro	ckville, M	ID 20850
	Sta Registr		31. Date filed (Month Day, Year) 20	NO DESCU	strar's Signature					

		•	State of Maryland / Dep State of Maryland / Dep Figure State of	artment of Health and M Histificate of Death	lental Hygie Reg.	2004 41556
	Dhuniai		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer 3. Time of Death
	Physici /Medic		Janet Kerr Fosler		December	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Shady Grove Nursing Home 5. Social Security 61/159 6. Sex 7. Age (In yrs. last birthday	Rockville If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomery 9. Birthplace (State or Foreign
H	Funeral Director		5. Social Security 61,59 220-48- 6059 6. Sex 1 □ M 2 □ F 85 Yrs.	Months Days Hours Min.	April 26	Country (State of Yorking), 1919 England
	and *	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Maryli f sho	tor	MD Montgomery Gaitl	nersburg		1 X es 2 No
	1 the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with	alD	9815 Sailfish Terrace	20886	Ur	nited States
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be indified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
5-0036	72 hor	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business/Industry
2121	within	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	housewife		home
7.0		0	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid	den Sumame)
Maryland		To B	Hugh Miller	Mary (Crawford P	Kerr
an	2 sho and h is ma	i 3	, , , , , ,	ing Address (Street and Number or Run		
	s 1 and 2 should if Health and Men Item 27 is marke other traumatic			Sailfish Terrace		
altimore,	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	matory or other place) see Crematory 12/28	101	Location - City or Town, State
Balt	permit. Pages Depertment of I Important: If Ite any injury or of		21. Signature of Funeral Service Licentee	22. Name and Address of Facility Rapp Funeral and Cr 1933 Gist Avenue Si	remation S	Services
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	law Tashasandia		2 / 0015
В	Lamine	lus en	Sequentially list conditions. b.	cular Tachycardia		
	nsit	mine	cause. Enter Underlying Cause (Disease or injury	-i a		
<u> </u>	execu in and ial-tra	Examiner	that initiated events c. Os eoarthrit resulting in death) Last Due to (or as a consequence of):	.18		
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P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	juires that n signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?
Division of Vital Records,	The law requir ate has been s' page 2 should	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ita		BeC	25. Was case referred to medical	26. Place of Deat	n (Check only one)	
<u></u>	S 0	To	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			e 6 □Other (Specify)
o uo	ding In.		27. Manner of Death 1 Natural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Divis	in the se	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.			
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
)	,		Colos	D28656	De	ecember 27, 2004
	H		30. Name and codiess of person who completed cause of death (Item 23a) (Type Dr. Ravi Passi 8609 Second Avenu	o, Print) 1e Silver Spring MI	20904	
	Sta		31 Date filed (Month Day Year) 32 Belistrar's Signature	farles		
	Regist	ar	JAN 0 3 2005 Janes 25 pt	The state of the s		

			Plea	ase Type or Pri State of M		d / Depa	artment of H	lealth a		-	ygiene	9	
	Physici		1. Decedent's Name (First, Midd FREDERICK	lle, Last) S. GUSTA	FSON	Cei	tificate of	Death		2. Date of D Month		•	3. Time of Death
	/Medio Examir			ITAL OF BAL	TIMO		4b. City, Town, o	MORE	= ci	77	40	County of De	ath
	Funeral Director		5. Social Security Number 013-20-8155 Usual Residence of Decedent	6. Sex 7. A	7 7	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of B (Month, D 7/28/.	Dav Year	9. B	rthplace (State or Foreign Country)
	r tha Marylan r 28a-f show modified et	Irector	MA BR	ISTOL	10c. City	y, Town or Lo					10g. Ci	tizen of What C	10d. Inside City Limits
020	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or items 23a or 28a-f show aumatic event, the Mydical Exat Inchinal to Indilited at	by Funeral Director	79 LINDEN STI 11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces rried 12 Yes 2 1	?		02° Was Decedent of H f Yes, specify Cub	780 dispanic Orican, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or N Rican, etc.)	lo-	USA 14. Race - Am Black, Wh Specify:	
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ıaı yıarı	2 should ba and Mental Is marked of aumatic ev	To Be	17. Father's Name (First, Middle, MAURICE DUS	STAFSON ship (Type, Print)			g Address (Street	MA and Numbe	RIE r or Rura		ber, City o	or Town, State,	Zip Code)
2	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra		AGNES F. GUST 20a. Method of Disposition XXBurial 2 □ Cremation 4 □ Donation 5 □ Other (3)	3XX emoval from State	' !	lace of Dispo emetery, cren	INDEN STI sition (Name of natory or other place OLL CEM.	ce)		ate	20c. L	.780 ocation - City o INTON , N	
П	Physician Physician		23a. Part Enter the disease, d shock or heart failure. Lis Immediate Cause (Final disease or condition	FORY FINK #I r complications that cause only one cause on each	MO114 d the death ine.	8 4:	. Name and Addre 26 CRAIN er the mode of dyin	HIGHW	AY S	., GLF	EN BU		
·	cate be exacuted by Medical by State but and but and the putial transit	dicai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as out to to as out to do as o	. ಪ ರವಿಗತತ್ತು	uence of):							
.O. DOY O	if that the death certificate be led by the attending physicial detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	,				23d. Date of de Month	blivery Day Year
- (cp -	equires that an signed bould be det	by	Part II. Other significant condition ATHERO SCLT	•				en in Part I.					o the cause of death?
יייייייייייייייייייייייייייייייייייייי	: The law re cate has be . page 2 sho	Completed	CONGESTIVE MUZTIPLE		FAIL	URE				24a. Wa: auto perf 1 Yes	s an opsy ormed!! 2 No	prior to death?	utopsy findings available completion of cause of
NISION OF ARE	To the Hospitel or Attending Physicien: The law requires that the death certricate be within 24 hours after death. To the Lunaria Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendia invest 2 Accident 3 Suicide 6 Could 4 Homicide determ	Hospital: 12 Inpati 28a. Date of Inj (Month, Di igation not be nined 28e. Place of In	ay Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nur	rsing Hom 2	8d. Describe	idence how injur	d Number or A	acify) ural Route Number,
ָ	To the Hospitel or within 24 hours afte To the Funeral Discompletely filled in	Medical Cer	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis of and manner st	of my know	wledge, death	occurred at the tir restigation, in my o	ne, date and pinion, deat	d place, a	nd due to the	cause(s)	and manner a	s stated. e to the cause(s)
	within To the comple	Mec	29b. Signature and title of certifie	Nam	MD		29c. Licens		190	76		te signed (Mon	-
	Sta		30. Name and address of person PRANITH 31. Date filed (Month, Day, Year)	A A / A / A / B / B / B / B / B / B / B	N/		(1)	NAI	1+05	PIZA	20	F BA	LTIMORE
	Registr	rar	JAN 0	9 7002 B	ALL S								

PRANITHA
31. Date filed (Month, Day, Year)
JAN 0 3 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician /Medical **Examiner**

Funeral Director

28a-f show Examinar count be notified at 5 230 Items 72 hours after "neturel", or the Medical

12 should be filed within 72 h and Mental Hygiene. 7 Ie marked other than "no s 1 and 2 s if Health an permit. Pages 1
Department of E
Important: If ite
eny injury or ot
once.

Baltimore, Maryland 21215-0036

Priysician /Medical Examiner

burial-transit attending physician and use as the the

Division of Vital Records, P.O. Box 68760 certificate be Hospitel or Attending Physicien: this After within 24 hours after death. To the Funerel Director: A

State

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year EONART Month 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death If Under 1 Year | If Under 24 Hrs. N/A 5. Social Security Number 7. Age (In yrs. last birthday) 8. Days of Birth (Month, Day, Year AUG. 5, 1913 Birthplace (State or Foreign Country) 6. Sex Days Hours Min 1 ₹ M 2 □ F Yrs. 214-01-3333 91 MD Usual Residence of Decedent 10c. City, Town or Location 10b County 10a State 10d. Inside City Limits Director BALTIMORE BALTIMORE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 SLADE AVENUE #605 21208 Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1. ☑ Yes 2 □ No USCG
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No þ Specify WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHOTOGRAPHER **PHOTOGRAPHY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GREIF LEONARD AMY **FEDERLEICHT** ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN GREIF / WIFE 1 SLADE AVENUE #605 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 12/31/2004 PIKESVILLE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sap tuy of Fune al Servic Aice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can ny that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia disease or condition resulting in death) WEEK Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibillation 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year) TROJ Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

32_Registrar's Signature

600 North

31. Date filed (Month, Day, Year)

Wafe Street, Tower 110, Baltimure,

	an	Grace		-	L.	C1	adden			Mo			Year	1
/Medio		4a. Facility Name (If not institution	1 aive street		L.	GLa		Town, or I	ocation of E		ember	31, 20		11:15
xamir	ier	372 Sunshine							tmins			,	rol.	1
neral ector		5. Social Security Number 216-18-9225 216-18-8225	6. Sex 1 ☐ M 2	0 138 E	e (In yrs. las	st birthday) Yrs.	If Under		If Under 24	Hrs. 8. Dat Min. (Mo	e of Birth onth, Day, Y		9. Birthp Court	lace (State or Fo stry) aryland
2 000		Usual Residence of Decedent 10a, State 10b. County			10c City	Town or Lo	cation						1	0d. Inside City L
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28a	Funeral Director	10e. Street and Number	1011			v	10f. Zip		5 T.		100	J. Citizen of Wh	hat Cour	itry?
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27 is r trau		Roxanne Miller		Daught	er					Pike			2120	
item othe		20a. Method of Disposition			20b. Pla	nce of Dispo	sition (Nam	ne of		Date		c. Location - C		
<u>~</u> ≿		1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (S		val from State		-	-			n. 3.	2005	Sykesv	i11e	MD
Importent: any injury o pose.	l	21. Signature of Funeral Service	Licensee	0	1/		. Name and	The second secon				stersto		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 828 AM NDREA 2004 DECEMBER 28 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOS PITAL BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗷 F 2/6-68-3928 Usuat Residence of Decedent MAR Director the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MARKANO LOALTIMORE ALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 CIRCLE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT 125 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporent: If Item 27 is marked othe any liuty or other traumatic event, 9DRg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ASKINS OOSEVELT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOAM HUF 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1A Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BUTUS CEMETERY 01-04-05 BALT MORE 21. Signature of Funeral Service Licensee 22. Name and Address of F 23a. Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC ARRYTHMIA WITH HYPOTENSION /Medical Due to (or as a consequence of) Examiner CORONARY ARTERY PISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit PNEUMONIA the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No o 9 Unknown 9 Hlnknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown MYCCARDIAL ISCHEMIA, ATRIAL FIBRILLATION CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? HYPOTHYROIDISM 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 🔲 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☑Inpatient 2 ☐ ER/Outpatient 2 3 DOA To the Hospitel or Attending Pl within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 🗋 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 28,2004 000 Stuti Shankar RES MD STUTI SHANKAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21239 RAVEN 5601 LOCH BOULEVARD BALTIMORE MD 31. Date filed (Month, Day Year) 3 32. Registrar's Signature 2005 State Registrar

within 2

Registrar DHMH 17 Rev 1/2001

Hora,

29b. Signature and little of certifier

29c. License number DO022483 29d. Date signed (Month, Day, Year) Documber 28, 2004

30. Name and address of person in completed cause of death (Item 23a) Typer Pript)

STUART JACCBS MD 3US JUSTIL Dr. Glan Burnie, MD 21061

ORIGINAL

32. Registrar's Signature

Leon Hunt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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nend T	State of Maryland / Department of Health and Mental Hygien [] [] []	407

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	Physicia	an	Decedent's Name (First, Middle, Last) Leon H	·~+				Month	Day Yo	3. Time of Death
	/Medic		4a. Fecility Name (If not institution, give street and number)	ınt	4b. City, Town, or	Location of		Decembe	4c. County of	
	Examin	er	1231 West Lombard Street		Baltimor	е			NA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt		If Under 1 Year Months Days	If Under 24	Hrs. 8	Date of Birth (Month, Day, Y	'ear) 9	Birthplace (State or Foreign Country)
	Director		211 01 3300	Yrs.				8-14-5		Md
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Lo	cation					10d. Inside City Limits
	Mary f sh	tor	Md. NA Ba	alti	more					1 Yes 2 No
	h the or 288	irec	10e. Street and Number		10f. Zip Code			100	g. Citizen of Wha	at Country?
	ath will	ralD	1343 Kitmore Rd.			1239			US	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. It is Medical Exameter must be notified an once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 ★ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates:	1	Vas Decedent of His i Yes, specify Cubar ☐ Yes 2 🌠 No	spanic Origii n, Mexican, I Specify:	n? (Specif Puerto Ric	y Yes or No- can, etc.)		American Indian, White, etc. Black
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Baltimore,	permit. I Departm Importal any inju		21. Signature of Funeral Service Licensee		Name and Addres			Balti	more, M	d. 21202
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Box.	death certificate be executed te attending physician and ed for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)				23d. Date o Month	f delivery Day Year
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of V	Physician: this certific al director,	ToE	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 EP/Ou	tpatien	t 3 DOA Othe	r. 4 🗆 Nurs				Specify) at scene
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Division	al or Atta s after de il Diracto	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury · At home, fa building, etc. (Specify) Found at reside:		eet, factory, office		28f Ba	Location (Stre City or Town, 1timore	et and Number of State 1231 Md	W. Lombard St.
	To the Hospital or Attand within 24 hours after death To tha Funaral Diractor: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge 2 ☑ Medical Examiner: On the basis of examination and manner stated.	, death	occurred at the tim restigation, in my op	e, date and inion, death	place, and	due to the cau	se(s) and manne	er as stated. due to the cause(s)
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)	15%.		Best F. Moster m		0.0	C.M.E.		De	ecember	26, 2004
	Buty		30. Name and address of person who completed callse of death (Item 23a) (
	Q AA		Dert F. Mortin 11	1 P	enn Stree	et, Ba	ltimo	ore, Mar	yland 2	1201
	Sta Registr		31. Date filed (Morith, Day, Year) JAN 0 3 2005 32 Registrar's Signature	Son	de					
				-						

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of a

Registrar

death (Item 23a) (Type, Print)

skn

2000 Regisfrar's Signature

29c. License number

111 Penn Street Baltimore MD 21201

OCME

29d. Date signed (Month, Day, Year)

December 31, 2004

			1 - For Stata Registra	nd item	State of I	Maryland / Donath of g845 7.	Depart	tment d ∂∂a∉ ⊞	of He	ealth a leath	and M	ental Hy	/giene	000	11.	1. 1	ECI
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o	Physi this c	7	1 X Yes 2 No 27. Manner of Death		Hospital: 1 X Inpa			B DOA	Other:	4 🗌 Nurs	ing Home	∋ 5 ☐ Resid	lence 6	Other	(Specify,)	
Division of	utending F death. ctor: After y the funer	atlon	1 X Natural 2 ☐ Accident	5 Pending investigate		jury 28b. Tir <i>ay Year)</i> Inji	ury	1	njury at Work? 1 🔲 Yes	2 🗆 No		d. Describe h	iow injury	occurred			
Divis	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifical completely filled in by the funeral director; is	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Place of I	njury - At home, farn etc. (Specify)	n, street, f	factory, offi	ice	200	28	f. Location (S City or Tow	Street and n, State)	Number	or Rural	Route Nun	nber,
	To the Hospi within 24 hour To the Funer completely fill	edical (29a. Certifier 11 (Check only 2 one)	Certifying F	Physician: To the bes aminer: On the basis and manners	of examination and/	death occ or investig	curred at the gation, in m	e time, ny opini	date and on, death	place, an occurred	d due to the d at the time, d	ause(s) a date and p	and mann place, and	er as sta d due to	ted. the cause(:	s)
	To the within 7 To the comple	Me	29b. Signature and titl	e o certifier				29c. Lic	ense ni	ımber		2	29d. Date	signed (f	Month, D	ay, Year)	
	,		/	1				r	060	-C 1	7		121	75	100	1	
ı	DID		30. Name and address					t)						61/		-1	
	/\- <u></u>		Frederick 31. Date filed (Month,	Beaver	s, M.D. 97	15 Medica	al Ce	enter	Dri	ve,	Suit	e 105,	Rocl	kvill	le, l	<u>4D</u> 20	850
	Stat Registre			Day, Year)		trar's Signature	-										

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H	ealth and Mo Death	ental Hygie	ene 004	41565
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Carvilla N. He.				-	2. Date of Death Month December	Day Year 23, 2004	3. Time of Death 7:50A M
	Examir		4a. Facility Name (If not institution, give s Manor Care-Bethe			4b. City, Town, or Bethesda	Location of Death		4c. County of Dea	th
	Funeral Director		019 10 2940	7. Ag	e (In yrs. last birthday, 82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y August 25,	(ear) 9. Bir	thplace (State or Foreign buntry) Sachusetts
	e Maryland la-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with th	al Director	10e. Street and Number 7830 Heatherton La	ine		10f. Zip Code 20854	4		Citizen of What Co	•
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examinational Legisland at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:	No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2X No	n, Mexican, Puerto P	city Yes or No-	14. Race - Ame Black, Whit	nican Indian,
Maryland 21215-0036	I within 72 ho iene. r than "natur Itre Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5	(Give	dent's Usual Occupa b kind of work done d DO NOT use retired) Ousewife	ution furing most of working)	g 16	b. Kind of Business	,
yland?	12 should be filed and Mental Hygis is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) George Figgs					na Thorne	iden Sumame) er	
e, Mar	1 and 2 sho Health and tam 27 is m		19a. Informant's Name/Relationship (Ty) Linda Aquirre/Daug 20a. Method of Disposition			ng Address (Street a Heatherton	n Lane, Po	tomac, Ma	aryland 2(0854
Baltimore,	t. Partmer		1 ☐ Burial 2 【XCremation 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Feneral Service License		Montgomery	matory or other place Crematorium 2. Name and Address	30, 20	004 B	ethesda,]	Maryland
Ba	Depa Depa Impo any ir		1/hos	MOI	1420 R	ockville, Ir ockville, M	aryland 208	Montgomery 50		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Metasta Due to (or as Seizure	ntic Breast a consequence of): e Disorder		, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
8760,	licate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Ordorfying Cause (Disease or injury that initiated events resulting in death) Last	Pu1mona Due to (or as	a consequence of): ary Embolis a consequence of): ttic Diseas		:S			
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome	of pregnancy 2 Petal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	quires that on signed by uld be deta	ed by Ph	Part II. Other significant conditions con Hypertension	tributing to death bu	ut not resulting in the u	nderlying cause giver	n in Part I.			the cause of death?
Vital Records,		Completed						24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
Division of Vit	ling Ph	ation: To Be	25. Was case referred to medical examiner? 1	ospital: 1 🗌 Inpatie 28a. Date of Injur (Month, Day		nt 3 DOA Other	at 28		e 6	ify)
Divis	oital or Attandurs after deathurs Director:	Certification:	3 Suicide 6 Could not be determined	building, etc				City or Town, S.		
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b.	edical	29a. Certifier (Check only one) Sertifying Physical Examin	ician: To the best of er: On the basis of and manner sta	of my knowledge, death examination and/or in- ted.	n occurred at the time vestigation, in my opi	e, date and place, an inion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Complet	Σ	29b. Signature and title of certifier	16	1	29c. License D5	number 3691		Date signed (Month ember 23,	
İ	U		30. Name and appress of person who cor Ajay Reddy, M.D.	6320 D	emocracy B	lvd., Beth	nesda, Mar	yland 20	817	
	Sta Registr		31. Date filed (Month Day, Year) JAN 0 3 2005		r's Signature					

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day December 31, **Physician** 2004 9:18A Jean-Louis Hirsch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Potomac Rebecca House If Under 1 Year Months Days 8. Date of Birth (Month, Day, Yea If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Hours Min. 1XM 2□F 70 1934 June 1, France Director 577-86-7898 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
net: If item 27 is marked other then "netural", or Items 23a or 28a-f show must if item 27 is marked other then "netural", or Items 23a or 28a-f show my or other treumstic event. The Medical Event and the retilified at my or other treumstic event. The Medical Event and the retilified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 √ Yes 2 □ No Director Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20016 France 4706 Yuma Street, N.W. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) International Elementary/Secondary (0-12) College (1-4or 5+) 5+ Translator/Revisor Monetary Fund 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Ruth Weill André Hirsch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If item 27 is any injury or other tree once. 4706 Yuma Street, N.W., Washington, D.C. Barbara Hirsch-Herpers/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State January 2, 1 Burial 2 Cremation 3 Removal from State prium, Inc. 2005

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 2005 * 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signatur Liveral Service Licer Wisconsin Avenue M00803 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Paralysis Agitans 5 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 X No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nome Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death e Hospitel or Attending Pl 24 hours after death. e Funerel Director: Atter ti Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number D23127 December 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5530 Wisconsin Avenue, #925, Chevy Chase, Maryland 20815 Kevin G. Nealon, M.D. 31. Date filed (Month, Day, Year) State Registrar JAN 03 2005

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan	d / Depa		lealth an	d Mental H		04 41567	
1	Dhuciai		1. Decedent's Name (First, Middle, Last)					2. Date of D		3. Time of Death	
	Physici /Medic		M. Lindsey	Hag	ood				nber 30,		
	Examin	er	4a. Facility Name (If not institution, give s 1836 Metzerott Rd			4b. City, Town, o		eath		nty of Death Lnce George's	
_	Formanal		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year		Hrs. 8. Date of B			
	Funeral Director			IM 2□F 78	Yrs.	Months Days		May 1	irth Year) Pay, Year) 1926	9. Birthplace (State or Foreign Country) Florida	
	e Marylan la-f show	ctor	10a. State 10b. County Virginia Prince V		y, Town or Lo	Manass	sas			10d. Inside City Limits Yes 2 □ No	
215-0036	th with the 23a or 28	al Dire	10e. Street and Number 10290 Cedar Ridge	e Dr.		10f. Zip Code	20110		of What Country? ced States		
	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show ha Madical Examirar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? ty Tyes 2 ☐ No if Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cub. 1 ☐ Yes 2\(\frac{1}{2}\)XNo		? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Ri Bi	ace-American Indian, lack, White, etc. cify: White	
	thin 72 ho e. an "netur Medical	To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of d)	working		Business/Industry	
7	filed withi Hygiene. other than			5+		Archite				eral Government	
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Beginnerth: If them 27 is marked other than "netural; or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating in all the redifficial and once.		17. Father's Name (First, Middle, Last) Nesbitt	Hagood				Name (First, Middle hany	e, Maiden Sumi Coz		
			19a. Informant's Name/Relationship (Typ. Doris F. Hagood	/ Wife	. 1029	0 Cedar	Ridge D	r Rural Route Num r., Manas		m, State, Zip Code) A 20110	
	Pages 1 nent of He ent: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)			osition (Name of matory or other plan te Cremate		/31 /04		n-City or Town, State	
Balti	permit. Departri Importe any inju		21. Signature of Funeral Service License	ge ·	2 R	2. Name and Addre	ral and	Crematio			
	Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the deat le cause on each line. Esophag Due to (or as a conseq	eal Ca	ter the mode of dyir				Approximate Interval Between Onset and Death Months	
.O. Box 68760,	death certificate be executed e attending physician and ad for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of intry that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	that the death certifica ed by the attending ph detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)	4			Date of delivery Month Day Year	
ds, P	uires that signed b ld be deta	Completed	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	inderlying cause giv	ren in Part I.			ntribute to the cause of death? 3 Probably 4 Unknown	
Records,	Physicien: The law requires that the this certificate has been signed by the tail director, page 2 should be detached.		a					24a. Wa aut per 1 🗆 Yes	s an 24b opsy formed? 2 No	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
<u> </u>		Be	25. Was case referred to medical examiner?	lospital:		oth Oth	0.0	Death (Check only		Friend's	
on of	ding Phys	Medical Certification; To	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?					ome 5 ☐ Residence 6 ⚠ Other (Specify) Home 28d. Describe how injury occurred		
Division of Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or 1							n (Street and Number or Rural Route Number, Town, State)	
	To the Hospitel within 24 hours a To the Funeral I completely filled										
	To the within To the comp	Me	29b. Signature and title of certifier	1//		29c. Licens	e number			ned (Month, Day, Year)	
)	X		Cun 6	fulce MD32864 De					Dece	December 31, 2004	
	12,		30. Name and address of person who con Ari D. Fishman				Washing	gton D.C.	20037		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 200	32 Registrar's Signa	ture	aste s					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year 730 pm JIGGETTS, SR. recember 27, 200 Μ. 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore General Hospital Varyland Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 XM 2 ☐ F 242-30-1496 81 11-8-1923 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2X No MD GWYNN OAK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1121 ST. AGNES LANE APT. 322 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1943-46 1 Never Married 2 Married 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BARBER BARBER SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SMITH JIGGETTS BETTIE GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) IDA B. JIGGETTS/WIFE 1121 ST. AGNES LA. APT 322 BALTIMORE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEM. PARK 1-4-2005 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MARYLAND 21217 unes thenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, x, or heart failure. List only one cause on each line. shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Interval Between Onset and Death entricular Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical **Examiner**

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Pages 1 and 2 should be

traumatic event, the Medical Examinar Hust be notified at

Funeral Director

Be Completed by

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division of Vital Records.

Examiner Be Completed by Physician/Medical ٩ Certification;

Hospitel or Attending Physicien: The law requires that the death certificate be executed

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 Accident

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Was an autopsy 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No

25. Was case referre examiner?	
27. Manner of Death	5 Pending

investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

and manner stated

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

3 🗌 Suicide

29a, Certifier

4 Homicide

29c. License number 89529 29d. Date signed (Month, Day, Year)

MD 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

Mad

State Registrar anaanathan 32. Regerrar's Signature JAN 0

		1 - For Stete Registrar	State of Maryla		rtificate of	Death	R	eg. No.	4156		
Physic /Medi		Decedent's Name (First, Middle, Last) PAUL JEFFERSON			2. Date of Dea Month FCDN BE	Day Year					
Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Death		4c. County of De	ath		
		BALTIMORE VA ME			BALTIM			NA NA			
Funeral Director		214-14-1029	7. Age (In yr 1 M 2□ F 87	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day AUG I, I	9. E VIR	irthplace (State or Foreig Country) GINIA		
A.C.		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	cation				10d. Inside City Limit		
Ba-f show	Director	MARYLAND NA	BAI	TIMORE					1⊠Yes 2□N		
filed within 72 hours after death with the Maryland Hygiene Hyberthan "natural", or Itame 23a or 28a-f show int, the Medical Exactive Fraust be rediffed at	Dire	10e. Street and Number 5318 BELLEVILLE AVENUE			10f. Zip Code 21207		1	0g. Citizen of What (USA	Country?		
	Funeral		12. Was Decedent Ever in	U.S. 13. V		Hispanic Origin? (Spec	ify Yes or No-		nerican Indian,		
d other than "natural", or Itamesevent, the Medical Examinar in		Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				Black, White, etc. Specify: BLACK		
in "natural", Medical Ext	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retire	pation during most of workin d)	g	16b. Kind of Busines	ss/Industry		
other than /ent, the M	mo.	3	NA NA	AUTOMO	OTIVE TECHN	TICIAN	*	CARS			
b d la b y	To Be C	17. Father's Name (First, Middle, Last) ALEXANDER JEFFERSON									
item 27 is marke other treumatic		19a. Informant's Name/Relationship (Ty) PAUL JEFFERSON JR. SON				and Number or Rural ROAD, APT. 10			Zip Code)		
t; if item 27 i 7 or other tre		20a. Method of Disposition 1	emoval from State	-	natory or other pla	*		20c. Location - City			
any injury or o		4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET. CFM. JAN 4, 2005 OWINGS MILLS, MARYLAND 21. Signature of Funeral Privide Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME P.A.									
- 4 0		638 N. GILMOR STREET BALTIMORE, MARYLAND 21217									
cian dical liner		23a. P.M.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death of the Conset and De									
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):									
e burial-tra	cal Exar										
tached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year					
e de		Part II. Other significant conditions con		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow							
ine taw requires mat me deam certifica ate has been signed by the attending phy page 2 should be detached for use as th	Completed by						24a. Was as autops perform	y prior to ned? death?			
		25. Was case referred to medical				26. Place of Death	1 Yes 2		s 2 No		
is certific director,	To Be	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing Hom			ecify)		
Ilng Ph After th funeral		27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred							
d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)									
To the Funeral Director: completely filled in by the	Medical (
E E	×	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Mor	oth, Day, Year)		
8					72	2186	D	ECFMRER	25,2004		
***		30. Name and address of person who co	moleted cause of death (Its	em 23a) (Type I		2130			23/2004		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12 00:30 Richard Keevy · /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Gien Burnce Nursing Home Glen Burnie, MD Ann Annale! If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 №M 2 🗆 F Director 217-16-2266 Sept 8, 1923 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at 1 ☐ Yes 21 No Directo Finksburg Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4170 Louisville Road 21048 death v Funeral USA permit. Pages 1 and 2 should be filed within 72 hours efter deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other there any injury or other trainer. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∑Yes 2 □ No
If Yes, Give
Year or Dates: 1943-45 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Wood Worker Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin Keeney Blanche Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon D. Burton Daughter 1403 Rowe Drive, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial Gard. 1/3/05 Finksburg, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Road tin ares Eline Funeral Home Reisterstown, MD 21136 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) pnemma Examiner Physician/Medical Examiner signed by the attending physician end d be detached for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Advanced pementia Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? AAA - Stable Sizel- Not operated 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate has 1 Yes Plane 1 ☐ Yes 2 ₺ No or Attanding Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Usursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Matural 5 Pending n/n after death. Director: Aft 1 ☐ Yes 2 ☑ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital 29a. Certifier (Check only one) Medical 11/ Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40061312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRANCH RD GLEN BURNE, MD 21060

DHMH 16 Rev 6/95

Registrar

PURVI

31. Date filed (Month, Day, Year)

SHAH

JAN 0 3 2005

7445 E PURNACE

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene [] [] 1- State Registrar AMEND TTFM #1 PER ME C839 1/03/05 JH 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 19, 2004 **Physician** 12:13 A M Michael G. Keller MICHAEL G. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** South Bound Route 3 at McNew Road Gambrills Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 1945 Massachusetts Director 024-34-0700 59 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at Springfield 1 ☐ Yes 2 No Massachusetts Hampden Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 01108 USA "natural", or Items 23e 106 Bronson Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after at Hygiene. other then "natural", or Ite 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical and tool designer 12 engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental Figure 1 is marked of Anna Lavery ပ George T. Kelley 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Journ, State, Zin Code) 106 Bronson Terrace, Springfield, MA 01108 permit. Pages 1 and 2 st Department of Health and Importent: if item 27 is n any injury or other traun Lina Kelley - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State | Date | 20c. Location · City or Town, State | 12/24/04 | Springfield, | Cemetery | 22 Name and Address of Facility Hubbard Funeral Home, Inc. | 4107 Wilkens Avenue, Baltimore, MD 21229 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 14/UVIES Priysician MILIPIE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner: 1/1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) at scene P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred A Certification: After 5 Pending Natural 12:09 death. 2 Accident 3 Suicide М 1 ☐ Yes 2 No motor vehicle investigation 12/19/04 accident after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) Route 3 South South 4 Homicide Striet at MCNIW Rd. Gambrills (MD) within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. December 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABILL CAL 4 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 321 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

JAN 0 3 2005

		•	For State Registrar	State of Maryla		rtificate of L		•	Reg. No.	001	41572		
	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) DEWEY KING 2. Date of Death Month Day Year 16:16 Pm										
	Examin		4a. Facility Name (If not institution, give SAINT AGNES	e street and number) HEALD+CARE		4b. City, Town, or B	Location of Deat	HORE	4c.	County of Death			
	Funeral Director		5. Social Security Number 6. S 219-10-4541	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	h y, Year)	9. Birth Cou Ten	place (State or Foreign ntry) Nessee		
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits		
	e Man le-f sh liffe 1	Maryland Baltimore Baltimore 106. Street and Number 107. 7 Avabutus Avanus 27.47 Avabutus Avanus 1107. Zip Code 27.47 Avabutus Avanus 1108. Street and Number									1 ☐ Yes 2 X No		
	ath with th		10e. Street and Number	Arbutus Avenu		10f. Zip Code 212				ven of What Cou	-		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heath and Mental Hygiene. If item 27 is marked other then "naturel", or Items 23e or 28e-f show or other treumetic event, the Modical Examinational De notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No.) 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No. Specify:					No- 14. Race - American Indian, Black, White, etc. Specify: White				
5-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of wo	rking	16b. Kir	nd of Business/In	dustry		
212	d within piene. r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		ayout Per:			Ellicott Machine Corp.				
nd	be filed tal Hygid d other event, t	Be	17. Father's Name (First, Middle, Last,					me (First, Middle,					
Maryland	should be nd Mental marked c umetic ev	2	Sylvester 19a. Informant's Name/Relationship (King	19h Maili	ng Address (Street a	Cora		Inkno		Code)		
	and 2 sleatth an m 27 is r		Christopher King	(SON)		Arbutus A							
Baltimore,	2 = 0 = 2	3	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			osition (Name of matory or other place en Mem. P		Date 1/2005		cation - City or To Burnie	own, State , Maryland		
Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licer			2. Name and Addres CCUIIY-PO 37 E. Pat					21225-1856		
Real Control	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of)										
.O. Box 68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Acute Non-Q wave Myocardial Infurction Due to (or as a consequence of):						Days			
	ng as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						2	3d. Date of delive	ery Day Year		
<u>α</u>	To the Hospitel or Attending Physicien: The law requires that the death ce within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	by	Part II. Other significant conditions contributing to death portnot resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death				
of Vital Records,		Completed				autopsy prior to completion of cause of death?							
Vita		Be	25. Was case referred to medical examiner?	Hospital:	7.500	Othe)r	ath (Check only o					
on of		tion: To	-	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury	4 🗆 Nursing r	Home 5 Resid			y)
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (S City or To	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		edical C	29a. Certifier (Check only one) 1 ★ Certifying Pr 2 ★ Medical Example 1	nysician: To the best of my kr miner: On the basis of examin and manner stated.	be best of my knowledge, death occurred at the time, date and place, and basis of examination and/or investigation, in my opinion, death occurred nner stated.			e, and due to the urred at the time,	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause		tated. o the cause(s)		
		M	29b. Signature and title of certifier Muclum Mr	med, MD		29c. License	6698		- mater	signed (Month, CEMB	Day, Year) ER 30,2004		
	Ŋ		30. Name and address of person who Dr. Nadeem /	1hman 90	0/1	ton AV	enue	Baltin	none	, MD	21229		
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 3	32. Registrar's Sign	St. A	barle							

KING, DEWEY

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert R. Klein 27, Dec. 2004 6:04 p M /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis ElderCare Severna Park Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1**⊠**M 2□ F 75 Director 190-22-9718 Yrs 22,1929 Mar. PA Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location If item 27 is marked other than "naturel", or Items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits MD Anne Arundel Director Severna Park 1 ☐ Yes 2√2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 24 Truckhouse Road 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc e filed within 72 hours after Il Hygiene. other than "naturel", or Ite 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No ģ Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Special Projects Manager Oil17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hr Important: If item 27 is marked oftany injury or other traumatic even Be Edward Klein Johanna Kramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David E. Klein/Son 7846 Regal Heron Circle, Naples, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dec. 30 2004 30, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Yocum's Cemetery Grill, PA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. ritchie Hwy, Severna Park, MD 21146 23a Part 1. Enter the disease, or confiplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Rause (Final disease of condition resulting in death) **Physician** 11 brovas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ysician and e burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical the attending phys IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Pro 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Vital 1 Yes 2 10 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Other: 4 Varsing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 10 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 Datural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical o the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50725 person who completed cause of death (Item 23a) (Type, Print) Hwy Millerville, MS 21108 8601 Voterans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registr <i>a</i> r	State o	f Marylan	-	artment of H				-		
	Physici	an	Hegistrar 1. Decedent's Name (First, Middle)	Michael	.I. Kell		runcate or	Deaur	2	2. Date of Dea	Da	y Year	8. Time of Death
	/Medic		4a. Facility Name (If not institution			- y	4b. City, Town, o	or Location o		Decemb		30 , 2004 County of Deat	
	Examin	er	Washington Adve		,			a Par				ontgomer	
	Funeral	_	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8 Min.	Date of Birt (Month, Day	h		nplace (State or Foreign untry)
и	Director		220-38-4966	1⊠M 2□F	61	Yrs.	Months Days	Hours	Milli.	Jan. 30	0, 19	943 Wash	ington, D.C.
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	Mary f sho	tor	Maryland Monte	omery			Bethesda						1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number	, o mo i j			10f. Zip Code				10g. Cit	izen of What Co	untry?
	th with	alD	6307 MacArthur	Blvd., A	pt. B-1		2	0816			Uni	ited Sta	tes
	r dea	Iner	11. Marital Status		dent Ever in U.		Was Decedent of H	lispanic Orig	gin? (Speci	fy Yes or No-	- T	14. Race - Amer Black, White	
36	s afte	y F.	1 ☐ Never Married 21 Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	re		1 ☐ Yes 2√2 No	Specify:		, ,			hite
8	within 72 hours after death with the Maryland ene. then "raturel", or Itams 23a or 28a-f show the Madical Examplat nual be notified at	ed b	15. Decedent	Year or Da	ates:	16a Dece	dent's Usual Occup	nation			16b K	ind of Business/i	
215	hin 72	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1	-4or 5+)	(Give	kind of work done DO NOT use retired	durina most	t of working		100.10	ind of Dusinessi	ildustry
21215-0036	ad with	Completed by Funeral Director	Clementary/Secondary (0-12)	2	*401 3+)	Photo	grammetr	ist			Fed	eral Gov	vernment
Maryland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, I					18. Mothe	er's Name (i	First, Middle,	Maiden	Sumame)	
yla	1 Men narke	²	George Michael	-						M. Moy			
Mai	d 2 st th and 7 is n treun		19a. Informant's Name/Relationsh Sandra Kay Kell				ng Address <i>(Street</i> MacArthun						
<u>ق</u>	1 an Healt tem 2		20a. Method of Disposition	y/WIIE	20b. P	lace of Dispo	sition (Name of		Dat	θ .		cation - City or T	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If it man 27 is marked other than "naturel", or itams 23a or 28a-f show any injury or other treumatic event, the Medical Examinational bandlined at once.		1 Burial 2 Cremation 4 Donation 5 Other (Sp		State		natory or other plac Crematoriu		Januar 2005				
三	mit. F partm sorter r injur		21. Signature of Funeral Service L		TROTA							nesda, M	
ä	P P F F S	X 0	Kuy	~	M0019	8 30	obert A. O West Moi	Pumph: ntgome	rey Fu erv Av	ineral e. Roc	Hom kvi	ie/Rockvi 11e. MD 2	ille, Inc.
	*		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the death	h. Do not ent	er the mode of dyir	ng, such as	cardiac or r	espiratory arr	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	SIXON	6021	n inju	14					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	,						
Ь		-	Sequentially list conditions,	0	or as a consequ	Avres	7						
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		cliom		カー スー						
oʻ	exect an and rial-tra	Exa	that initiated events resulting in death) Last	C.	or as a cons	Friend Com-	7						
8760	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal		d									
39 ×	e as t	Med	IF FEMALE:	T									
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fetal	death 3	Ectopic pregnancy	1			1 2	23d. Date of deliv Month	ery Day Year
o.	res that the de signed by the a be detached t	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	ant at time of de own	eath 5	Other (specify)						
صِّ	that ned by deta	y Ph	Part II. Other significant conditio	ns contributing to de	eath but not resu	ulting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute to	he cause of death?
rds	quires n sign	ed by			-					1 □ Y	es 2[□No 3□Pro	babiy 4 DUnknown
Vital Records,	aw require is been sig 2 should b	Completed								24a. Wasa		24b. Were auto	ppsy findings available
Ä		E								autops perform		death?	mpletion of cause of
Ita	nysicien: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only on	<i></i>		
>	Physicien: r this certific ral director,	2	1 Yes 2 □ No			ER/Outpatien	t 3 DOA Oth	er: 4 □ Nur	rsing Home	5 🗌 Reside	ence 6	3 □Other (Speci	fy)
Division of	ding F h. After funera	lon	27. Manner of Death 1 Natural 5 □ Pending		of Injury h, Day Year)	28b. Time of Injury	28c. Injun Worl			d. Describe ho	ow injury	y occurred	
SIC	uttendi death. ctor: A y the fu	licat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	of Injury - At ho	me farm str	M 1 [Yes 2□N		Location /St	treet an	d Number or Dur	al Route Number,
2	el or Attend safter death I Director: / d in by the f	Certification;	4 Homicide determi	buildir	ng, etc. (Specify	<i>(</i>)	soi, factory, office		201	City or Town	n, State,)	ar riodie ivariber,
	spit ours ours fille		29a. Certifier 1 Certifying	g Physician: To the	best of my know	wledge, death	occurred at the tim	ne, date and	d place, and	due to the ca	ause(s)	and manner as s	tated.
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medical E	xaminer: On the ba and mann	isis of examination states.	tion and/or inv	estigation, in my o	pinion, deat	h occurred	at the time, d	ate and	place, and due t	o the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	A			29c. License		_	2	9d. Date	e signed (Month,	Day, Year)
, ,	21		· an	~ 0 Ox	>)		476	222			12/	31/20	504
/	y		30. Name and address of person v Lawrence Kelly,					ma D-	wle 1/1	2001	ი		
	Sta	e	31. Date filed (Month, Day, Year)	39. R	egistrar's Signa	ture	ide, Iako	ша Ра	rk, M	J 2091.			
	Registra		JAN 03	2005 Ken	egistrar's Signal	14							

			1 - For Stata Registrar	State of Maryland		rtment of H			ZUIIIs	41575
	Physici	0.0	Decedent's Name (First, Middle, Last)			mouto or	Douiri	2. Date of Dea	ath Day Year	3. Time of Death
	/Media	cal		larence Q. Knig	ght	45 City T	.1	Decemb	er 28, 200)4 4:10 A M
	Examir	ier	4a. Facility Name (If not institution, give s	e Bethesda			r Location of Death Bethesda		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		gomery rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	86	Yrs.			September	30,1918	Virginia
	iryland show	_	10a. State 10b. County	10c. City, To	own or Loc	cation				10d. Inside City Limits
	the Ma 28a-f s	Director	Maryland Montgor	nery			Bethesda		10.00	1 ☐ Yes 2 No
	3e or		7831 Aber	deen Road		10f. Zip Code	20814		10g. Citizen of What C	
	r deat	Funeral		Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
36	irs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Diverced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1.117.17.17	ĺ	☐ Yes 2X No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	
2-0	within 72 hours after death with the Maryland ana ana "atlanta", or Items 23e or 28a-f show than "natural", or Items 23e or 28a-f show the Marital Examinating the notified at	eted	15. Decedent's Educ (Specify only highest grade	ation 16	6a. Decede	ent's Usual Occup	ation during most of work	ina	16b. Kind of Business	White VIndustry
121	within and the within "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. O	O NOT use retired	a)			
d 2	Hygie other	Be Co	12 17. Father's Name (First, Middle, Last)			Hardwar	e Salesma 18. Mother's Name	-	Reta Maiden Sumame)	ail
ylan	ould be Menta arkad atic ev	To B	Ado1	hus Knight				Ann	ie Monroe	
Mar	12 sho h and 7 Is mu trauma		19a. Informant's Name/Relationship (Typ	l l					r, City or Town, State,	
Б	f Healt Healt tem 2		Christine Anne Made 20a. Method of Disposition	20b. Place	of Dispos	ition (Name of	7.42		cel, Maryla 20c. Location - City or	
ШO	Pages nent ol ant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 【 Other (Specify)	moval from State	じっせん	atory or other place Mausole	' Tames	ary	Silver Sor	ing, Marylan
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglena. Importent: If item 27 Is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, I'lle Modical Experiment must be notified at 90ce.		21. Signature of Emeral Service License	M0033	Bet 5 Bet	Name and Address hesda-Cl	ss of Facility Rob nevy Chas Mary Land	ert A. I e. Inc 20814-35	Sumphrey Fu 7557 Wisco	ineral Home/ onsin Avenue
			23a. Part1. Enter the disease, or comples shock, or heart failure. List only one	ations that caused the death. D	o not ente	r the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	_Acute Tubular		osis				Onset and Death Days
	Examiner			Due to (or as a consequence	ce of):					
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):					
	xacuta and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
8760,	icate be exacutad physician and s the burial-transit	dlcal E	d.							
ဖ	ertificating physes as the	Med	IF FEMALE:							
Box	leath certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
P. O.	that the de ad by the a detachad	hysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
Records, F	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions cont	ributing to death but not resulting	g in the und	derlying cause give	en in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	the cause of death?
		Completed			-			24a. Was al autops perform 1 \(\text{Yes} \) 2	y prior to	utopsy findings available completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:	-	Oth	26. Place of Death			
	g Phye	n: To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 Inpatient 2 ER/C	. Time of	28c. Injury	at Nursing Hor		nce 6 Other (Spe	cify)
lois	Attending F death. ctor: After y the funera	atlo	1 X Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Work	(? Yes 2 □ No			
Division of	or A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (St City or Town	reet and Number or Ru , State)	ural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier (Check only one) 1 1 Certifying Physi 2 Medical Examina	cian: To the best of my knowled ar: On the basis of examination a and manner stated.	ge, death o and/or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To To Com	2	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Monti	h, Day, Year)
_	11		30. Name and address of person who com	poleted cause of death (Item 222) (Tuna B		D0055694		December	28, 2004
-	$\mathcal{N}_{X,i}$	1	Alox Mathur, M.D. 4	000 Olney-Layto	onsvi	lle Road	Olney, M	aryland	20832	
	Sta Registra	te	31. Date filed (Month, Day, Year) JAN 0 3 2005	32. Registrar's Signature	Good	E)		•		

			1 - For Stata Registrar	State of Maryl	and / Depa <i>Ce</i> a	artment of Hea rtificate of De	alth and Me eath	ental Hygie Reg	ene 2004	41576
	Physici	an.	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			Kumar	Khanna			December	29, 2004	9:00 PM
	Examin	er	4a. Facility Name (If not institution, given 14400 Chrisman			4b. City, Town, or Lo	yds		4c. County of Death	merv
	Funeral		Social Security Number 6. 5	Sex 7. Age (In)	rs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth		place (State or Foreign
	Director		N/A	1 XX M 2□F 82	Yrs.	Months Days	Hours Min.	(Month, Day, Y Aug. 2,	1920	India
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				IOd. Inside City Limits
	Mary Fe sho	tor	Maryland Montg	omerv		Boyds	S			1 ☐ Yes 2X No
	th the or 28s	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
	ath wi	ral	14400 Chrisman				0841		Indi	
	lterns	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No	n U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spec Mexican, Puerto R	cify Yes or No- tican, etc.)	14. Race - Ameri Black, White,	
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23s or 28s-f show the Madical Examiner must be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/CXNo S	Specify:		Specify: As	ian Indian
5-0	72 ho netur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupatio	n ng most of workin	g 16	ib. Kind of Business/In	dustry
12	within ane. than	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) perations (Officer		Railr	oad
<u>d</u>	Hiled Hygie other	Be Co	17. Father's Name (First, Middle, Las				. Mother's Name	(First, Middle, Ma		
ılan	uld be Aental rked tic ev	To B	Achraj	Ram H	Khanna		Lakhwa	anti	Khan	na
Maryland	2 sho and h is ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street and	Number or Rural	Route Number, C	City or Town, State, Zip	Code)
	1 and Health sm 27 Iher tr		Anila Gupta / Da 20a. Method of Disposition	ughter	144 b. Place of Dispo	00 Chrisman			s, MD 208	
DOL	nt of h		1 ☐ Burial 2/13/Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, crei	natory or other place)				
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service Price			e Crematory 2 Name and Address o app Funeral				ille, MD
ă	Depar Impor any ir		Juste Droke	uann Moo3	82 g	app Funera. 33 Gist Ave	e Silve	emation er Sprin	Services g.MD 209	10
П			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	leath. Do not ent	er the mode of dying, s	such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			CARDIO VASC	WELL DI	SEASE		Onset and Death
	Examiner		1	Due to (or as a con-	sequence of):					
		ner	Sequentially list conditions, Lany leading to it, it added to cause. Enter Underlying	b. Due to (or as a con	sequence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	ficate be executed physician and is the burial-transit	al E	Tooling in doubly base	Due to (or as a con:	sequence or):					
687	E 170 m	edical		_ d						
Вох	death certifii e attending p ad for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Ectopic pregnancy			23d. Date of delive	
	0 0 0	sici	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of 100 Unknown		Other (specify)			Month	Day Year
P.0	that the sed by detac	, Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause given in	n Part I.	23e. Did tobac	cco use contribute to the	ne cause of death?
Vital Records,	luires n sign	d by		_				1 ☐ Yes	2 No 3 □ Prot	ably 4 Unknown
CO	law requir as been si 2 should	Completed						24a. Was an	24b. Were auto	psy findings available
m m	The late happage	Som						autopsy performe 1 Yes 2	d? death?	mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0	3. Place of Death	2	- 1	
of	Phys r this ral dir	1. 10	1 XYes 2 No 27. Manner of Death	1 ☐ Inpatient 2	2 ER/Outpatier 28b. Time of			e XX Residence 3d. Describe how	e 6 Other (Specification)	y)
ion	Attending Physician: The r death. scion: After this certificate his yithe funeral director, page	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	r) Injury	Work?	2 □No		, , , , , , , , , , , , , , , , , , , ,	
Division	l or Attendated after death Director:	Certification:	3 Suicide 6 Could not to determine determined			eet, factory, office	28	3f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
	lospital o		00-0-45		leader to the					
		Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or in	n occurred at the time, overtigation, in my opinion	date and place, ar on, death occurred	d due to the caus d at the time, date	se(s) and manner as s and place, and due to	ated. the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		(One	29c. License nu		29d.	Date signed (Month,	Day, Year)
}	0	,		- mu).	(0,16)	DISC	. 6		Decembe	r 31, 2004
	1		30. Name and address of person who				. 011	D = =1 == • 1 1	- MD 000	
	Sta	te	Carl Margolis M	32 Registrar's Si			te 211; 1	KOCKV111	e, MD 208	04
	Registr		JAN U3 7	2005 Bases	Si Ag	action				

בט			1 - State Unpend Item 2	State of Marylar 3a&27 per me	nd / Depa G839-1	artment of l Tiffeato of	Health a B eath	nd Mental Hy	/giene Reg. No		1 1 100 000 0
	Physici	on	1. Decedent's Name (First, Middle, Last)			1		2. Date of D		Year Year	3: Time of Death
	/Medi		George Rich		ta			Decemb			0820 P M
	Examir	er	4a. Facility Name (If not institution, give : Johns Hopkins Hosp:			4b. City, Town, Baltimo		Death	40	c. County of Deatl n/a	h
9	Funeral Director		213-04-8000	7. Age (In yrs	. last birthday) 8 Yrs.	If Under 1 Year Months Days		Min. 8. Date of B	irth Pay, Year 195	9. Birth	nplace (State or Foreign untry) ryland
d	and w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. fnside City Limits
	Mary a-f sho	tor	Md. n/a		Ва	1timore	9				1 XYes 2 No
	or 284	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Co	untry?
	s 23a	eral	231 South Durh		10 10		21231	0.00		US.	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic avent, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 ☒Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1		was Decement of f Yes, specify Cut □ Yes 2X No	an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
21215-0036	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occu kind of work done	during most of	of working	16b. K	(ind of Business/I	
121	filed within Hygiene. Ithar than " int, the Mer	mple	Elementary/Secondary (0-12) 9th	College (1-4or 5+)	life.	DO NOT use retire	ed)	SI WOINING	C:	- C 1	D - 1 + * · · ·
9	filed v Hygie othar t	O a	17. Father's Name (First, Middle, Last)		<u> </u>	aborer	18. Mother	s Name (First, Middle			Baltimore
Maryland	should be nd Mental markad c	To Be	Walter George	Kuchta			Cath	erine Mi	ldr	ed Szyr	manski
/an	2 sho and I is ma		19a. Informant's Name/Relationship (Ty					or Rural Route Numb			
e,	1 and Health am 27 ther t		Walter G. Kucht 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		St. Bal		Md.	
πor	ages ant of nt: If it		1X Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	cemetery, crer	natory`or other pla		an 6,2004		1timore	
Baltimore,	permit. Pages of Department of Himportant: If its any injury or of once.		21. Signature of Funeral Selvice License	14	22	. Name and Addr	ss of Facili		ki	Funera	Home, PA
			23a. Part1. Enter the disease or complishock, or heart failure. List only or	cations that caused the dea						,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Cirrhosis o							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):						
	ocuted nd transit	Examiner	cause. Enter Underlying Cause Lisease or injury that initiated events								
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as a conse	quence of):						
289		edical		l							
Вох	eath certifi attending p	In/M	230. Was decedent pregnant	3c. If yes, outcome of pregn 1□Live birth 2□Fet		Ectopic pregnanc	v			23d. Date of deliv	very
	Attanding Physician: The law requires that the death certif reach. reach. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of a		Other (specify) _	у			Month	Day Year
P.0.	res that the de signed by the a be detached f	/ Phy	Part If. Other significant conditions cor	tributing to death but not re-	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	quires in sign uld be	ed by						1 🗆	Yes 2	No 3□Pro	babiy 4 Unknown
900	e law requin has been si ge 2 should l	Completed						24a. Was		24b. Were aut	opsy findings available ompletion of cause of
H	ding Physician: The In. After this certificate hatfuneral director, page	Com						auto perf	ormed? 2 \Baseline	qeaur?	2□ No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:	£7	Ot		f Death Check on			
of	y Phys er this eral di	n: To	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	XER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	ry_at	ing Home 5 ☐ Res 28d. Describe			ify)
ion	utanding F death. ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Infury		rk? Yes 2 □ No				
Division of Vital Records,	or Atta ifter de Diracto in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of fnjury - At h building, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location (City or To	Strøet ar wn, State	nd Number or Rui e)	al Route Number,
	Hospital 14 hours a Funaral I		29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my kn	owledge death	occurred at the ti	me date and	place, and due to the	Called/e	and manner as	stated
	To the Hospital or Attantwithin 24 hours after death To the Funaral Director: completely filled in by the	Medical	(Check only 2XXMedical Examinone)	ner: On the basis of examinand manner stated.	ation and/or inv	estigation, in my	opinion, death	occurred at the time,	date and	d place, and due	to the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and title of certifier	(81 00		29c. Licen				te signed (Month,	
			Mullimine 1)	restruct	nun	0.C.M				iary 1, 2	
			30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type 11	1 Penn S	treet,	Baltimore	, Ma	ryland 2	21201
	Sta	te ar	31. Date filed (Month, Day, Year)	32. Projistrar's Sign	ature	Carles					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 23:54 **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath **Examiner** MEDICAL BALTIMORE MERLY CENTER If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number **Funeral** Months Hours 1 □ M 2 X F Davs Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinant and indired at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number SA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type, Print) mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) ANDREA 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 12/27/2004 Woodlawn, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE Immediate Cause (Final disease or condition resulting in death) RESTIRATORY 3hrs 12min Physician /Medical Due to (or as a consequence of) **Examiner** ENTREME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by page 2 should be 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No this certificate 1 Tyes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Medical Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending м 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. in a 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier. D62150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sol st Paul te mamilia eva 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 3 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Lovell 2004 1100 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Pavs | Hours | Min. | February 6,1922 | Baltimore, STUAKE HOSPITA BAITIMORE FRANKLIN **Funeral** 5. Social Security Number 6. Sex (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF 82 Yrs. 214-14-8929 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show iner must be notified at 1 ☐ Yes 2 🎇 No MD. Baltimore Be Completed by Funeral Director Rosedale 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1911 Wilhelm Avenue 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. other traumatic event, the Medical Examiner Affiled Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 õ 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, importent; If item 27 is marked other than "n eny injury or other traum-time." Elementary/Secondary (0-12) College (1-4or 5+) 12 years Secretary Crab House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarance T. Hollenshade Edna Mac Donald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter J. Kellner 2917 Overland Avenue, Baltimore, Md. 21214 nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 Durial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 3, 2005 Dundalk, Md. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Limb 2 To Peripheral VASCULAR DISCUSE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Year Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, FAILURE, CHF, GI Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? performed? res 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check onl one examiner' 1 ☐ Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) this 28a. D te of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No , after death investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of centifier 29d. Date signed (Month, Dey, Year) o Pin Qui RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 DR. SudhaKAR PADINENI

31. Date filed (Month, Da

32. Registrar's Signature

9000 FRANKLIN SQUADE DR. BALTIMORE Md. 21237

				State of Mai				•	aiene	•
			1 - State Registrar			ertificate of		-	Reg. Ng? () () [41581
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	/Media			Lola Ruth	Luke			Decemb	er 28, 200	04 3:00 A M
	Examir	er	4a. Facility Name (If not institution, give s				or Location of Death		4c. County of De	
-	Funeral		5. Social Security Number 6. Sex	s Hospital	In yrs. last birthda	y) If Under 1 Year				itgomery Sirthplace (State or Foreign Country)
	Director		523-16-9086]M 2∰F	88 Yrs.	Months Days	Hours Min.		y, Year) 15, 1916	Country) Colorado
	and w		Usual Residence of Decedent 10a, State 10b, County		Oc. City, Town or	Location				10d. Inside City Limits
	Maryl f sho	tor	Maryland Montg		7,		1 0 1			1 ☐ Yes 2 X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumstic event, "to Medical Exam or must be notified at once.	Director	Maryland Montg	Omery		10f. Zip Code	lver Spri	ng	10g. Citizen of What	Country?
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	tems	Funerai		12. Was Decedent Ev Armed Forces?	er in U.S. 13	B. Was Decedent of I If Yes, specify Cub		pecify Yes or No Rican, etc.)		ne <i>r</i> ican I <i>n</i> dia <i>n</i> ,
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Ž	should nd Me mark matic	ဥ	HO 19a. Informant's Name/Relationship (Ty)	race Emmic _{De Print})		iling Address (Street	and Number or Rus		lin Nolan or, City or Town, State	Zin Codo)
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Baltimore,	s 1 a of Hez item othe		20a. Method of Disposition		20b. Place of Dis	position (Name of		Date	20c. Location - City of	or Town, State
<u><u>Ë</u></u>	Page nent c ent: If		1 Burial 2 Cremation 3 R 1 Donation 5 Other (Specify)	emoval from State	Parkla Memori	ematory or other pla wn al Park	Janu	ary 2005	Rockvill	e, Maryland
3alt	permit. Departi Import any inj		21. Signature of Funeral Service License	/ ,	D .	22. Name and Addre	ess of Facility Roh	ert A	Pumphrey F	uneral Home/ onsin Avenue
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N	I or Atten after deati Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At nome, farm, s Specify)	treet, factory, office		City or Tow	treet and Number or F n, State)	Rural Route Number,
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	To the Hospital or a within 24 hours after to the Funeral Dire completely filled in b	edicai	(Check only 2 Medical Examin	er: On the basis of ex and manner state	(amination and/or i	nvestigation, in my o	pinion, death occur	red at the time, o	late and place, and du	e to the cause(s)
	With To t	Σ	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
i	/,-		1 mhilde				D-32332		December	28, 2004
	1/)		30. Name and address of person who cor			•) C#1 (المساعدة	Man-1 - 1 C	20002
	Sta	100	Suresh K. Gupta, M. 31. Date filed (Month, Day, Year)	32. Registrar's	Signature) Silver ?	spring,	maryland 2	20902
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	h with the 23a or 28a	Funeral Director	10e. Street and Number 7 Weybridge C	ourt			10f. Zip		21146		10	g. Citizen of	What Coun	itry?	
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	as 1 and 2 st of Health and I Itam 27 is n r other traun		Colette Mesi 20a. Method of Disposition	ch/Wife	- a	7 We	ybrio	ge C	burt.		na Par	k MD	211 City or To	46 wn, State	
Baltimore,	permit. Pages Department of i Important: If its any injury or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (\$ 21. Signature of Funeral Service	Specify)	M	letro C		_	1	2004		altimo		MD neral Hom D 21146	e
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Division	To the Hospital or Attanding within 24 hours after death. To tha Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could 4 Homicide deterr	not be an Place of In	ijury - At ho tc. <i>(Specif</i>)	ome, farm, str	eet, factory			28f. L	ocation (Stre City or Town,		er or Rura	l Route Number,	
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	Registr	ar	JAN 0	3 2005		K A	real !								

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	Pĥysici	22	1. Decedent's Name (First, Middle, Las	t)				J. 200		2. Date of Deat Month		Yea	3. Time of Death)
	/Medi		Joseph S. Magg				· · · · · · · · · · · · · · · · · · ·			12	27	200	2145 PM	1
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	Funeral		5. Social Security Number 6/Se			ast birthday)	If Under		nder 24 Hrs.	8. Date of Birth			MORC lirthplace (State or Foreig Country)	n
	Director		212-20-3411	X M 2□ F	78	Yrs.	Months	Days Ho	urs Min.	8. Date of Birth (Month, Day Oct. 30	7,192	26 N	(d.	
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any lojury or other traumatic avant, the Medical Examinating must be routified ut ance.	by Funeral	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 No. If Yes, Give Year or Dates:		1	If Yes, spec			cify Yes or No- Rican, etc.)		Black, Wh		
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Maryland	2 shou and N Is ma		19a. Informant's Name/Relationship (T	ype, Print)						Route Number,			, Zip Code)	
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Baltimore,	. Pages Iment of Hant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ I '4 ☐ Donation 5 ☐ Other (Specify))	ce	adowri	natory or of	ther place)	Dec3	2004		idge	or Town, State	
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	Physician		23a. Part Enter the disease, or composed to the composed to th	lications that caused to the cause on each line	he death	Do not ente	er the mode	e of dying, suc	th as cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequ		1	,	1					_
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Sever Due to (or as a	consequ	<u> </u>	hem	ic c	ARdi	omyo	PA	IHY		
	ate be executed hysician and the burial-transit	Examiner	that initiated events	o. DM										
8760,	te be executed ysician and te burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequ	ence of):								
687	physicate s the t	edical	•	d										_
Box (death certifica e attending ph od for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Je				230	f. Date of de	elivery	
o.	ies that the death certifica igned by the attending ph be detached for use as th	hysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at ti 9□Unknown			Ectopic pre Other (spe					Month	Day Year	
S, D	es tha gned be det	by P	Part II. Other significant conditions co	1 0	. ,		ndertying ca	use given in f	Part I.				to the cause of death?	
ord	w requir been si should	eted	END STAge Ko	NAL FAI	/UR	É				1 ☐ Ye	s 2 🗆 N	No 3□F	Probably 4 Dunknown	
I Record	Physician: The law requires that the this certificate has been signed by the tall director, page 2 should be delached.	Completed by Physician/Med	ANEMIA							24a. Was ar autopsy perform 1 Yes 2	, -	prior to death?	autopsy findings available completion of cause of s 2 No	1
Vital	sician certific rector	Be	25. Was case referred to medical examiner?	Hospital:						(Check only one				
	y Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury	7	28b. Time of		3c. Injury at		e 5 🗆 Resider			ecify)	+
ion	ath. r: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No					
Division of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At hor (Specify)	me, farm, stre	eet, factory,	, office	2	Bf. Location (Str City or Town,		lumber or F	Rural Route Number,	Ī
	To the Hospital within 24 hours of the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of iner: On the basis of a and manner state	axamınati	rledge, death on and/or inv	occurred a restigation,	at the time, da in my opinion	te and place, as death occurre	nd due to the ca d at the time, da	use(s) an te and pla	d manner a ace, and du	is stated. le to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier				29c.	License num	ber	29	d. Date s	igned (Mor	ith, Dey, Year)	
)	1		Hay H.	Myint		אלא	D	470	190	ı	2/2	7/2	004	
	り		30. Name and address of person who co	ompleted cause of dea	ath (Item	23a) (Type, I	Print)		X n	IT 1		11.1	21237	
	Sta	te	31. Date filed (Month, Day, Year)	9000 F 1. Registrar	's Signati	ILI N	JQU	ARE	UR B	alli mo	RE	pia.	d/25/	
	Registr	_	JAN 0 3 200	3 Election	J.	1597								

			1 = For State Registrar	State of I	Marylan	-		nt of H		and M		giene Reg. No.		41584
	Physici	an	Decedent's Name (First, Middle, La	Duane E	lizabet	th Mor	an				2. Date of Dea Month Dece	Day	28, 2004	3. Time of Death 2:00 am M
1	/Medic Examin		4a. Fecility Name (If not institution, gir				4b. City	, Town, or	Location o		umbia	4c. C	County of Deet	oward
	Funeral		5. Social Security Number 6.			last birthday)	If Unde	r 1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birt	hplece (State or Foreign untry)
ĸ.	Director		579.32.7531 Usual Residence of Decedent	1□ M 2K F	8	30 Yrs.					February	2, 192	4	Maryland
	ahow	or.	10a. State 10b. County		10c. City	y, Town or Lo	ocation		olumbi	2				10d. Inside City Limits 1 Tes 2 No
	or 28a-	Director	Maryland 10e. Street and Number	loward			10f. Zi	p Code		<u> </u>		10g. Citiz	en of What Co	ountry? S.A.
	ne 23a	Funeral	6334 Cedar Lane	12. Was Decede		.S. 13.	Was Dece	edent of Hi			ecify Yes or No Rican, etc.)	- 1	4. Raca - Ame	ncan Indian,
900	hin 72 hours after death with the Maryland e. An "natural", or iteme 23a or 28e-f ahow Madical Examener rust be notified al	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	X4 0		1 🗆 Yes	2)XNo	Specify:	, Puerto	Hican, etc.)		Black, White Specify:	White
Maryland 21215-0036	within 72 he lene.	Completed	15. Decedent's E (Specify only highest gi	ade completed) College (1-4	or 5+)	16a. Dece (Give life.	kind of w	ork done d use retired,	uring most		ng	16b, Kin	d of Business/ meat p	Industry processing
ind 2	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Las			1					(First, Middle,	-115	Sumame) Knight	
aryla	d 2 should be th and Mental 7 le marked c traumatic eve	To	Geo 19a. Informant's Name/Relationship	rge Robey (Type, Print)							il Route Numbe	er, City or	Town, State, 2	
	and 2 ealth a m 27 le		Mr. Elberrt Swine	y Brothe	er-in-law	Place of Dispo			& Cour		vd. Ellicott		laryland 2 ation - City or	
more	or or or		20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec		ite C	emetery, cre Crest Lav	matory or	other place		12	/31/2004		1000	ille, Maryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatore of Funeral Source Lice		-MDIZ			and Addres	s of Facilit	y Home	e, P.A. Pike Ellico	ott City	MD 2104	3
*			23a. Part1. Enter the disease, or conshock, or heart failure. List ont	y one cause on eac	h line.			de of dying	g, such as	cardiac o	crespiratory at	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)		as a conseq		N/C		0700	, , ,			, , , ,	
. *	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	juence of):								
,092	te be executed ysicien and ie burial-transit	ical Exa	that initiated events resulting in death) Last	Due to (or	as a conseq	juence of);								
89			IF FEMALE:	G										
.O. Box	The law requires that the death certificat the bas been signed by the attending phy age 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		n 2 ∏ Feta tat time of d	I death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)				23	3d. Date of dei Month	ivery Day Year
<u>α</u>	uires that t i signed by id be detad	þ	Part II. Other significant conditions	contributing to dear	h but not res	sulting in the u	underlying	cause give	en in Part I			obacco us Yes 2		the cause of death?
Records,	The law require ate has been si page 2 should I	Completed			<u> </u>						24a. Was autor perfo	osy ormed?	24b. Were au prior to death?	Itopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical examiner?	Hospitali				Oth	200		(Check only o	опе)		
of	Phys this ral dir	1: To	1 ☐ Yes 2₽No 27. Manner of Death	28a. Date of	Injury	ER/Outpatie		28c. Injury Work	4/35/2 191		me 5 Resident			cify)
Division	Attending Part death. ector: After by the funer	Certification;	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on	Day Year)	Injury	M	10	<br Yes 2□		28f. Location (Street and	Number or Ri	ural Route Number,
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certif	4 Homicide determine	u building	, etc. (Specif	fy)					City or To	wn, State)		
	e Hosp 24 hou e Funer etely fill	edical	29a. Certifier 1 ☐ Certifying F (Check only 2 ☐ Medical Ext one)	Physician: To the baminer: On the bas and manne	est of my kno is of examina r stated.	owledge, dea ation and/or in	th occurre nvestigation	d at the tim on, in my of	ne, date an pinion, dea	id place, ith occurr	and due to the ed at the time,	cause(s) a date and	and manner as place, and due	s stated. to the cause(s)
	To the vithin To the compl	Me	29b. Signature and title of certifier				2	9c. License	number			29d. Date	signed (Mont	h, Day, Year)
	1		30. Name and address of person wh	e completed cause	of death (Iter	m 23a) (Tvne	. Print)	24	512	5		12	127	1021221
	.3		TARIG MAIN	nu() 2	01-10	19 B	ock	Ric	er	Nec	ik Ro	el P	Balh's	n to the cause(s) h, Day, Year) cut mcre
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. B	jistrar's Signa	ature	Fast	,						

Amend item#8,9,perFH,G839,1/3/05 TT State of Maryland 7 Department of Health and Mental Hygiene 2004 41585 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Margarita McCollam **Physician** 3:45 pm M December 28, 2004 /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (sville Pike

7. Age (In yrs. last birthday)
Yrs.

If Under 1 Year If Under 24 Hrs. 8. Days Hours Min.

Months Days Hours Min.

Yrs.

If Under 24 Hrs. 8. Days Hours Min.

July 29, 19

July 29, 1918 14115 Clarksville Pike Howard

9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 □ F <u>579 - 18 - 3183</u> Usuel Residence of Decedent 1918 Pennsylvania Director Pennsylvania 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ral, or itema 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Howard Highland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14115 Clarksville Pike 20777 U.S.A. Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No 1 and 2 should be filed within 72 hours after t Never Married 2 Married 1 ☐ Yes 2 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Specify. δ 3 □ Widowed 4 □ Divorced Year or Dates White "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Department of Defense Employee 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental Is marked of John Hyndman Tench 2 Margarita Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 14115 Clarksville Pike Highland, Maryland 20777 Mr. George E. McCollam Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State All County Cremation Services, Inc. 12/30/2004 22. Name and Address of Facility * 4 □ Donation 5 □ Other (Specify) Sykesville, Maryland Signature of Juneral Service Lice see Jeune 466 Slack Funeral Home, P.A. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carriac or respectively, MD 21043 shock, or heart failure. List only one cause on each line. Approximate Onset and Death immediate Cause (Final IA BETES MELLITUS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) OSTED POROSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Deneur IA The law requires that the death certificate be executed SENILE the attending physician and ched for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, THROM BOSIS NEWSNZ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Type 2 No detached 9 Unknown 9 🗀 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe REJSION 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed should abstructive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0056948 2004 PUTART CAME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #224 CSLUMBIA NO LANSINDA CLOUD LEAP COURT MD AME 877 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State Registrar

ORIGINAL

			1 - State Ragistrar	State of Maryland / Depa Cer	rtment of Health and M	lental Hygier	2001 11500
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Helen Catherine M 4a. Facility Name (If not institution, give street)		4b. City, Town, or Location of Death	December	Day Year 24, 2004 11:00 PM 4c. County of Death
	Funeral Director		Manor Care — Potoma 5. Social Security Number 577-07-0591 Usual Residence of Decedent	ac 7. Age (In yrs. last birthday) 93 Yrs.	Potomac If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 18, 1	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, Ita Madical Examinational be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Montgomer 10e. Street and Number 13701 Deakins Lane 11. Marital Status 12. Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade contents)	Was Decedent Ever in U.S. Ammed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: ion completed) College (1-4or 5+) Print) Print) 16a. Deced (Give in the complete of Disposementary, cremetery,	Vas Decedent of Hispanic Origin? (Speryes, specify Cuban, Mexican, Puerto □ Yes 2♥ No Specify: ent's Usual Occupation find of work done during most of worki NONOT use retired) istrative Assistan 18. Mother's Name Ida Mari g Address (Street and Number or Rura Deakins Lane, Da itton (Name of atory or other place) e Cemetery 31, 2	Ur acify Yes or No- Rican, etc.) 16b. We nt Te. (First, Middle, Maid e Wright Waste Number, City rnestown, ate 1004 ert A. Pun	v or Town, State, Zip Code) Maryland 20874 Location - City or Town, State Lver Spring, Maryland Luphrey Funeral Home
8760,	/Medical Examiner physician and prize transit the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of the complex of the com	tions that caused the death. Do not ente cause on each line.	r the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between Onset and Death 10 Days
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	in the past 12 months?	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Ectopic pregnancy Other <i>(specify)</i> derlying cause given in Part I.	23a. Did tobacco	23d. Date of delivery Month Day Year use contribute to the cause of death?
l Records,		Completed by	Congestive Heart	Failure		1 Yes 24a. Was an autopsy performed? 1 Yes 2 No.	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital	or Attanding Physician: tflar death. Diractor: After this certific in by the funeral director,	Certification; To Be	2 Accident investigation	oital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury - At home, farm, stree building, etc. (Specify)	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	(Check only one) ne 5 Residence 8d. Describe how inj	6 □Other (Specify) ury occurred and Number or Bural Boute Number.
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the fune	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medical Examiner: 29b. Signature and title of certifier	en: To the best of my knowledge, death of On the basis of examination and/or investand manner stated.	stigation, in my opinion, death occurre	d at the time, date ar	s) and manner as stated. Individual to the cause(s) at e signed (Month, Day, Year)
	Sta Begistr		30. Name and address of person who complete George F. Sengstack 31. Date filed (Month, Day, Year)				ember 28, 2004 1 20906-4709

State of Maryland / Department of Health and Mental Hygiene

				State of Ivia	•	•	ificate of		ivieritai i iy	Reg. No.	04 4	1587
		_	1. Decedent's Name (First, Middle, Las	st)					2. Dete of De Month	eeth Dey	3. T Year	Time of Death
	Physiciar /Medica	•	Mariano		Me	del				ber 23,	2004	11:33PM
	Examine	•	4e Fecility Neme (If not institution, give					4b. City, Town, or		h 4c. County	of Deeth	
			Randolph Hills N				# I bedor 1 Voor	Silver :	Spring	Mo	ontgomer	
	Funeral Director		219-23-4439	ex 7. Ag	e (In yrs. lest bir 74	Yrs.	Months Days		March	th 29, Year) 29,1930	O Argen	(State or Foreign ntina
	and w	-	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Loca	ation				10d. In	side City Limits
	Mary 1 sho	į	Maryland Howard				Co1	umbia			Kr.	∐Yes 2□No
	n tha	2	10e. Street end Number		l.		10f. Zip Code	·-		10g. Citizen of V	What Country?	
	th wit	<u>a</u>	9120 Lambskin	Lane				21045			gentina	
Baltimore, Maryland 21215-0020	filed within 72 hours after death with the Maryland Hygiene. Hygiene than "natural", or tierne 23s or 28s-f show into the Medical Examinet must be notified at hit. The Medical Examinet must be notified at	by Funeral Director	11. Maritel Status 1 ☐ Never Married 2 ☐ Married \$\timeg{X}\text{Widowed} 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 22.3 If Yes, Give Year or Dates:		1		Hispenic Origin? (Foan, Mexican, Pue Specify: Ar		Specify	e - American Ind ck, White, etc. v: Whi	
2-0	72 ho		15. Decedent's Ed (Specify only highest gra	Jucation ide completed)	16a.	(Give k	ent's Usuel Occu	during most of wo	orking	16b. Kind of Bi	usiness/Industry	
21	ithin la.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. Do	NOT use retire Mechan	ed)		Re	ailroad	
7	filad withi Hygiana. Ither than ent, in a M		12 17. Father's Neme (First, Middle, Last)				riecitati		me (First, Middle	, Maiden Suman		
au	Se	ne C	Ildefonso		Mede1				cisca	111/2/20	ellido	
يتح	should and Men marke umartic	0	19a. Informent's Name/Relationship (Type, Print)	196	. Mailing	Address (Stree	t and Number or F	Rurel Route Numb	per, City or Town,	Stete, Zip Code	9)
ž	tra tra		Lilana Medel /	Daughter		912	0 Lambs	kin Lane	, Columb	ia, MD	21045	
ore,	as 1 an of Haali Itam 2 r other		20e. Method of Disposition 1 ☐ Burial 2 ☒ Cremetion 3 ☐	Demousl from State	20b. Place o cemete	f Disposi ry, creme	ition (Neme of etory or other pla	ice)	Date Dec.	20c. Location -	City or Town, S	State
Ĕ	Pag ment: M		4 □ Donetion 5 □ Other (Specific		Ches		ke Crem		28,2004	Beltsv	ville, M	fD
3alt	permit. Pagas 1 an Department of Haai Important: If Itam 2 any injury or other once.		21. Signature of Funeral Service Licer	see		22. R	Name and Addr	ess of Facility eral and	Cremati	on Servi	ces	
	& D ⊆ # 8		Steple Dohn	nam 1	100382	9	33 Gist	Ave., S	ilver Sp	ring, MI	2091	
18	ga 189		23a. Part1. Enter the diseese, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do ne.	not ente	the mode of dy	ing, such as cerdia	ac or respiretory	arrest,	Inter	roximate val Between et and Death
	Physician /Medical		Immediate Cause (Final		Compost	1	Ucomt F	o.i.1			1	
Z,	Examiner		disease or condition resulting in deeth)	θ	Congest:			arrure				
		<u>ē</u>			Cardiom						i	
	ifficata be executed g physician and as the burial-transit	E	Sequentially list conditions,	b	Due to (or es e							
90,	oe execian a		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	C							1	
68760,	physi		that initieted events resulting in death) Last		Due to (or as e	consequ	ence of):					
×				d								
Box	Tha law requires that the death cart at has baan signed by tha attendin paga 2 should ba datached for usa	Physician/M	Part II. Other significant conditions o	ontributing to death b	ut not resulting i	n the unc	derivino cause o	iven in Part I.	23b. Did	tobacco use co	ntribute to the	cause of death?
P.0	that the de ned by tha a datached i	S L			•		,		10	Yes 2□No	3 Probably	XX Unknown
S, F	as tha gned ba da	2	Pneumonia								1	
ord	v require baan sig should b	9	Diabetes Mel	llitus Typ	e II				24a. Wa: perf	s an autopsy ormed?	available	utopsy findings e prior to tion of cause
of Vital Records,	law I	Completed								y	of death	1?
									***	Yes 2DNo	1 □ Yes	2 □ No
Ξ.	certificat rector, p	ne	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 ☐ ER/O	stantiont	3 DOA 0		eath (Check only	one) idence 6 □Oth	or (Specify)	
	Phys r this aral di	2	27. Manner of Deeth	28a. Date of Inju	iry 28b.	Time of	28c. Inju			how injury occur		
<u>o</u>	Attanding Physician: or daath. betor: Aftar this certific by tha funeral director,		1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation		y rear)	Injury		Yes 2 No				
Division	er dage rector	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Piece of in	ury - At home, fa	arm, stre	et, factory, office			(Street and Numb wn, State)	er or Rural Rou	ite Number,
	ital or irs aft rel Dir led in											
	To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: Attar completely filled in by tha funer	Medical	29a. Certifier (Check only one) 1 ★ Certifying Ph 2 ★ Medical Exam	nysician: To the best ninar: On the basis of and manner st	f examination er	e, deeth nd/or inve	occurred et the t estigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time	ceuse(s) and ma , date and place,	anner as stated. end due to the o	cause(s)
	of the omple	2	29b. Signature and title of certifier	n n	17		29c. Licen	se number		29d. Date signe	d (Month, Day,	Year)
	- 5 - 0			A 0.	-6/	. 1		D52261		Decem	nber 24,	2004
	6	1	30. Neme en 1 ddress of person who	completed cause of	deelh (Item 23e)	(Type, P	rint)					
_	Ψ		Alan R. Sega		1517	Hug	o Circl	e, Silve	r Spring	, MD 20	906	
	State		31. Dete filed (Month, Day, Year) JAN 0 3	32. Registr	er's Signature	1	2000					
(e g	Registra	Ħ	July 0 3	.00J	اند معد	S. Co.						

			1 For State	State of M	laryland / Dep				A A A 1	1 1500
			1. Decedent's Name (First, Middle	(ast)	Ce	rtificate of	Death	Reg.	MG. UU H	3. Time of Death
	Physic		Jessie	Gasch	Meto	-1 f		Month	Day Ye	ar
	/Medi Examii		4a. Facility Name (If not institution,				r Location of Death	December	4c. County of D	
1	LXdiiii	161	Wilson Health	-		1	thersburg			gomery
	Funeral		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		219-36-8333	1 ☐ M 2 🖾 F	96 Yrs.	Months Days	Hours Min.	July 9,	1908	Nebraska
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d, Inside City Limits
	Manyl f sho	5	Maryland Mont	gomery		Gaithe	vah			1 ☐ Yes 2 ₩ No
	the 1	rect	10e. Street and Number	50mer y		10f. Zip Code	sburg	10a	Citizen of What	21
	3a or	Ö	301 Russell A	Ave.		1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20877	1.09.	United	
	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show the Medical Evariner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	city Yes or No-		merican Indian,
9	after or Ita	F	1 ☐ Never Married ※XMarrie		No	1 Tes, specify Cuba 1 ☐ Yes 2XXNo	In, Mexican, Pueπο ι Specify:	Hican, etc.)	Black, W	
21215-0036	"natural", or	d by	3 Widowed 4 Divorced	Year or Dates:					Specify:	White
5	"nat	Completed	15. Decedent' (Specify only highest	s Education grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of worki	ng 16b	. Kind of Busine	ss/Industry
12	withi	dwg	Elementary/Secondary (0-12)	College (1-4or	5+)	eacher	1)		77	
d 2	Hygie other ent,	0	17. Father's Name (First, Middle, L			eacher	18. Mother's Name	(First, Middle, Maid	Educat	ion
Maryland	iges 1 and 2 should be filed within 72 ho nt of Health and Mental Hygiene. If item 27 is marked other then "natur. or other traumatic event, I'm Medical	To B	Frank	Gasch			Ada			vailable)
lan	and last me	ĺ.	19a. Informant's Name/Relationsh				and Number or Rura			a, Zip Code)
	l and fealth im 27 her tr	1 6	Richard Metcal:	Z / Son		-	Ave., Si			20910
Baltimore,	Pages 1 nent of H int: If ita		20a, Method of Disposition 1 Burial 2 Cremation	3 □Removal from State		natory or other plac	Θ)		Location - City	
Ħ	permit. Pages Department of Important: If it any injury or c		4 □ Donation 5 □ Other (Sp				ory 1/3/	_	Beltsvi	
Ba	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service 1	mann)	M00382 9	33 Gist A	sal and Cr ve. Silv	er Spring		
Г			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause only one cause on each I	d the death. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Doe	monta					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					3, 5
	2.44		Sequentially list conditions,	b. — Due to /or se						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
	al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
68760,	cate be executed physician and the burial-transit	dical		d						
	P Ga	a)			-1000					
Вох	death certifi e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of c	lelivery
	0 0	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown		Other (specify)			Month	Day Year
P.0	that the		Part II. Other significant condition	18 contributing to death b	uit not requiling in the		- i- P- 41	an- Dida-		
ds,	Se Se	d by	Tarrin one significant contains	is contributing to death o	at not resulting in the di	idenying cause give	я п Рап I.			to the cause of death? Probably 4 Dunknown
Ö	> 4	lete						24a. Was an		
Vital Record	0 4 0	Completed						autopsy performed	prior to	autopsy findings available completion of cause of
ital	sician; Ti certificate irector, pag	O	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 L Ye	es 2 No
_	ys diis	To B	examiner? 1 🗀 Yes 2 🗖 No	Hospital:	ent 2 ER/Outpatien	t 3 DOA Othe		ne 5 Residence	6 ∏Other /Sr	necify)
n of			27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	28c. Injury Work		8d. Describe how in		33.1)
Sio	Attanding r death. actor: After by the fune	catle	2 Accident investiga	ation	, , , , , , , , , , , , , , , , , , , ,		es 2 □No			
Division	or Attan fter deat iractor: n by the	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, stre c. (Specify)	eet, factory, office	2	8f. Location (Street City or Town, Sta	and Number or i	Rural Route Number,
	pital .		On Conting	Dhariel T	of much a second second					
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physicien: To the best xaminer: On the basis or and manner sta	examination and/or inv	occurred at the time restigation, in my op	e, date and place, ar inion, death occurre	nd due to the cause d at the time, date a	(s) and manner and place, and di	as stated. ue to the cause(s)
	within To the	Me	29b. Signature and title of certifier			29c. License		29d. [Date signed (Mo	oth, Day, Year)
ŀ	^) Xt	1 John	1.	0.	20148	D	ecember	30, 2004
	17		30. Name and address of person w	ho completed cause of d	eath (Item 23a) (Type,	Print)	^			30, 2004
			Oteven ()	olinsky m	0 911	Kussell	Hve, 6	aithersbu	m m	4
	Sta		31. Date filed (Month) ARNY (1)	2005 32. Figistr	ar's Signature	marke)	
	Registr	al		14000	NO JU PS					

			For State Registrar	Idiaal .	State of I	Maryland /	Dep		t of H	ealth a	and Me	ental Hy	/giene Reg. No C		41589
	Physic /Medi	cal	Decedent's Name (First, SUZANNE M. 4a. Facility Name (If not ins)	NIEL	SEN	arl .		Ab Cib.	Tour	1 continu	/	2. Date of D Month CCM	102 Day		
	Exami	ner	7985 NOLPAR							Location o	or Death			nty of Deal	
	Funeral Director		5. Social Security Number 213.34.6621		Sex 7. 1 □ M 2 F XX	Age (In yrs. last b	Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Bi (Month, D	rth ay, Year) 5 1925		thplace (State or Foreigr buntry) ELGIUM
	anyland show	_	Usual Residence of Decede 10a. State 10b. C			10c. City, To	wn or Lo	ocation		<u></u>					10d. Inside City Limits
	ith the M or 28a-f	Director	MD AN	NE AI	RUNDEL	GLEN	BUI	10f. Zip	Code				10g. Citizen	of What Co	1 Yes 2 No XX
	s 23a		7985 NOLPAR	K CT					061				USA		
36	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "naturel", or items 23a or 28a-f show event, if e Medical Examinat must be inclified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Div		12. Was Decede Armed Force 1 Yes 36 If Yes, Give	s? ₹No		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto Ri	fy Yes or Nican, etc.)	0- 14. F E Spe	Black, White cify:	
21215-0036	n 72 hou "nature	Completed t	15. De	edent's E			a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done d	ition fu <i>ring</i> most	of working	7	16b. Kind of		IITE Industry
212	should be filed within to Mental Hygiene. marked other than imatic event, It e M.	ошь	Elementary/Secondary (0	12)	College (1-4d	or 5+)		CCOUN					STATE	OF M	(ID
nd	al Hygi J other	BeC	17. Father's Name (First, M	ddle, Lasi	1)			100001			r's Name (First, Middle	, Maiden Sum		
yla	should be ind Mental I	10	FLORENT	NOEI	<u> </u>							E DELC			
Maryland	2 2 2 3		19a. Informant's Name/Rel										er, City or Tow		
	s 1 and if Health item 27 other to	-	R. SAUL MCC	UKMI	JK PERSUNA	20b. Place				CE-ANI	NAPUL		20c. Locatio		Town State
Baltimore,	Page ent o nt: If		1 Burial 2 remains 4 Donation 5 Ott	er (Speci	fy)	te cemet	ery, crei IEW	natory or of	TORY	INC	12.3	0.04	BALTI		
Ba	permit. I Departm Importai any injui		21. Signature of Funeral Se	. 16	23	2011	22 H	Name and	d Addres	s of Facility	ME P	.A.			
		0	23a. Part 1. Enter the disra shock, or heart fifther			MO114 ed the death. Do		26 CR	ATN of dvino	HWY S	SW CT.	EN BUE	NIE, M	D 210	Approximate
	Physician		shock, or heart failure Immediate ause (Final disease or condition	List only											Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	-	a	OCA RDI	47 of):	//	PA	RC1	1010				
п	Examiner		Sequentially list conditions	- 1	h H	IPERTE	EN	5101	1						
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Į											
	be executed sician and burial-transit	хаш	Cause (Disease or injury that initiated events resulting in death) Last	1	c. HYP.	ERLIPII as a consequence		MIA							
8760,	cate be ex hysician the burial	icai		l	_ d										
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 ₱ No 9 □ Unknown			2 Fetal death at time of death		Ectopic pre						Date of deli	very Day Year
S,	s that gned b	by Pt	Part II. Other significant co	nditions	contributing to death	but not resulting	in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco use co	ntribute to	the cause of death?
ora	w require been sig should b			,								1 🗆 '	Yes 2□No	3 🗆 Pro	obably 4 🛣 Unknown
		Completed										24a. Was autor perfo 1 \(\text{Yes}	osy ormed?	prior to c death? 1 \(\sum \text{Yes}\)	topsy findings available completion of cause of 2 No
Vital	Physicien: 7 r this certifical ral director, p	o Be	25. Was case referred to m examiner? 1 ☐ Yes 2 ☐ No	dical	Hospital:				Othe			Check only o		-	
ō	iding Physicie th. After this certi funeral director	n: To	27. Manner of Death	7 :-	1 ☐ Inpa 28a. Date of Ir	jury 28b.	Time of	t 3□ DOA	c. Injury	at			dence 6 0		ufy)
0	Attending r death. sctor: After oy the fune	atio		ending vestigatio	(Month, E	Jay Year)	Injury	М	Work′ 1 □ Y	? es 2 □ N	lo		. ,		
5	in the	Certification:		ould not be stermined	286. Place of I	njury - At home, f etc. <i>(Specify)</i>	arm, str	eet, factory,	office		281	Location (City or Tox	Street and Nun wn, State)	nber or Rui	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifier (Check only one) 2 Me	tifying Ph lical Exar	nysician: To the bearings: On the basis and manner	of examination at	e, death	occurred a	t the time	a, date and nion, death	place, and occurred	due to the at the time,	cause(s) and n date and place	nanner as	stated. to the cause(s)
	To the To the Complet	Me	29b. Signature and title of c		w	om o			License	number 2 49	0		29d. Date sign		
	,}		30. Name and address of pe Anita	Kha	ndelwar	mp 30	(Type,	Print) 504	K	Hant	over.	St B			ND 21225
- 9	Sta Registr		31. Date filed (Month, Day,	'ear)	32. Hegis	trar's Signature									
DHM	MH 17 Rev 1/2		JAN 0	3 200	5 Julies		form			<u> </u>		<u></u>			
						ORI	GINA	L							

				partment of Health and Nertificate of Death		2004	41590
	Physici	an	1. Decedent's Name (First, Middle, Last) Dorothy Nagel		2. Date of Death Month December		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Manor Care-Potomac	4b. City, Town, or Location of Death Potomac	December	4c. County of Death Montgome	
	Funeral Director		5. Social Security Number 182-10-8782 G. Sex 1 M 2 F 7. Age (In yrs. last birthdiction of the second of the seco	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 28	ear) 9. Birth Cou 1911 Penn	place (State or Foreign intry) sylvania
	Maryland	tor	10a. State 10b. County 10c. City, Town or Maryland Montgomery Potoma				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the Se or 28s	Direct	10e. Street and Number 11815 Gainsborough Road	10f. Zip Code 20854		Citizen of What Cou	,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *naturel', or items 23e or 28e-1 show any Injury or other treumatic event, The Medical Exacting must be routified at once.	by Funeral Director		3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:		14. Race - Ameri Black, White, Specify:	can Indian,
Baltimore, Maryland 21215-0036	I within 72 ho liene. r than *natur the Medical i	Completed	(Specify only highest grade completed) (G. Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) 1. Tance Agent	ng	b. Kind of Business/Ir	
and 2	d be filed ental Hyg ced other c event,	To Be C	17. Father's Name (First, Middle, Last) Frank Kooker		(First, Middle, Mai		
Mary	d 2 shoul th and Me 7 is mark treumati	ř		siling Address (Street and Number or Rura Smith Avenue, West	I Route Number, C		
nore,	pages 1 an of Heal of		20a. Method of Disposition 20b. Place of Discomplery, competery, competers,	position (Name of rematory or other place) Lawn Januar	ry 4,	c. Location - City or To	own, State
Baltir	permit. F Departme Importar any Injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Robe Rockville, Inc., 300 Rockville,	ert A. Pu	ckville, M mphrey Fur ntgomery 2	neral Home/
1	Physician /Medical		23a (Part I) Enter (the disease, or complications that caused the death. Do not a shock of death ailure. List only one cause on each line. Immediate Cause (Final disease or condition a. Colon Cancer resulting in death)	enter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
8760,	Examiner	dicai Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Chasse Criffly that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med		B∐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
S, D	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
al Record		Completed			24a. Was an autopsy performed	prior to condeath?	psy findings available mpletion of cause of
Division of Vital	Attending Physicien: The death. ector: After this certificate by the funeral director, pag	ertification; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	of 28c. Injury at 2		e 6 □Other (Specifing occurred	y)
Divis	or Dir	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 2	8f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	d at the time, date	and place, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifiers Legal up	29c. License number D52261		Date signed (Month, cember 30,	
0	717		30. Name and address of person who completed calse of death (Item 23a) (Typ Alan R. Segal, M.D., 1517 Hugo Circl	e, Silger Spring, M	aryland 2	20906	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ske			

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alicia Μ. Pryor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death **Examiner** HEALTH C most If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Social Security Number Birthplace (State or Foreign Country) 1 M 2 XF Yrs. Director 220-64-6140 10-12-55 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f shov The Madical Exampler must be nutified at Director Md. NA Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1805 Bloomingdale Rd. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is markad other than Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital 12th grade Admin. Assist. traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Watkins Percy Velveeta P Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If itam 27 is or other trai Nakia Slowe Daughter 1805 Bloomingdale Rd., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Greenmount Cem. 12-31-04 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 -March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular thant Direase Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 20 No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) Edera dann M.D. D0056092 December 23,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore, maryland 2/279 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month PANTO 18:42PM 30 2004 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7. Age (In yrs. last birthday)

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, N/A The Johns Hopking 7 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 215-64-8731 50 Yrs. Director MD. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD. N/A Completed by Funeral Director Baltimore Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3204 Hudson Street 21224 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years years Physicians Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Panto Hilda Ziegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Laura Panto Daughter 2323 Glenna Goodacre Apt 714, Lubbock, Texas 79401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If ite
any injury or ot
once. January 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart Of Mary Cem. `4 Donation 5 Dother (Specify) 3, 2005 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease of complications that caused the death. Qo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial disease or condition resulting in death) 48 hours /Medical Due to (or as a consequence of): Examiner Cardio my spa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ ype I Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an renal disease autopsy 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. 2 Accident investigation 1 TYes 2 TNo 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) December 30, 2004 RES-000

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 0 3 2005

600 North Wolfe Street

Baltimore MD 21287

Johns Hopkins Hospital

32 Registrar's Signature

	1 - State Registrar	State of Maryla		rtificate of l		•	Rag. No.2	04 4159
	1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	3. Time of Death
sician edical	Florence Nel	son Peters				DEMORTH HE	ERPay 9,	2004 8:15F
miner	4a. Facility Name (If not institution, give	e street and number) Medical Ce	enter	4b. City, Town, or		ath ISON	4c. County	of Death Baltimore
ral tor	528-14-1262		rs. last birthday) 38 Yrs.	Months Days	If Under 24 H		v. Year)	9. Birthplace (State or Fore Country) Utah
	Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Lim
ō	MD Balt	imore	Sparks					1 ☐ Yes 2 📉
Director	10e. Street and Number		- 1	10f. Zip Code			10g. Citizen of V	What Country?
				211	52		US	,
Funeral	11. Marital Status	12. Was Decedent Ever in		Was Decedent of Hi	spanic Origin?	(Specify Yes or No	- 14. Rac	e - American Indian,
leted by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Pue Specify:	erto Rican, etc.)		ck, White, etc. v: White
d b	3 X Widowed 4 □ Divorced	Year or Dates:	160 Door	deetle Herrel Occur			105 105-1-10	
Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	lurina most of w	orking	16b. Kind of Bi	usiness/Industry
Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+) 4		nemaker	,		Or	vn Home
Be Completed			11011		18. Mother's N	ame (First, Middle,		
To Be						Anderson		
Ance. To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ing Address (Street a			er, City or Town.	State, Zip Code)
1	Craig N. Peters/	Son		Box 619		MD 2115		,,
	20a. Method of Disposition		h Place of Disno	nsition (Name of		Date		City or Town, State
5	1 N Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	D	uraney '	matory or other place		1. 4,	m.:	
1	21. Signature of Funeral Service Licer	Me Me	emorial	Gardens 2. Name and Addres		.005	Timor	nium, MD
Suce.			Le	emmon Fune	ral Hom	e of Dul	aney Val	lley, Inc.
	23a. Part1. Enter the disease, or comshock, or heart after. List only			W. Pador				Approximate
ian	shock, or heart refere. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. ACUTE RE						Interval Between Onset and Death DAYS
cal ner	1	Due to (or as a cons		STRUCTI	ON			DAYS
- in	Sequentially list conditions,	b. Due to (or as a cons						
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
xar	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					
		4						
岩		. d.						
ician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre-		-			23d. Dat	e of delivery
5 वि	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy				o or delivery
<u>0</u>	1 Yes 2 TVNo		of death 5[Other (specify)			Mo	
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y Physician/Med		9□ Unknown		Other (specify)	en in Part I.	23e. Did to		nth Day Year
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Rag. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Riler Month Day Year Margaret December 25 2004 4 00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GENESIS ELDERCARE - TRUCKHOUSE ROAD PASADENA ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 XX 87 Yrs. 8/22/1917 MARYLAND

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

2 No

,2004

Year

1 ☐ Yes 2XXVo

Funeral Director

Physician

/Medical

Examiner

1 - For Stata Ragistrar

28a-f show al Hygiene.

Completed by Funeral Director

Be

2

death with the Maryland 7 is marked other than "naturel", or items 236 or 28a-f shov treumetic event, the Madical Examinationst be nutified at Pages 1 and 2 should be filed within 72 hours after nt of Health and Mental Hit: If item 27 Is marked oth ò Department of Importent: If eny injury or once. permit.

Maryland 21215-0036

Baltimore,

Pnysician /Medical

Examiner Physicien: The law requires that the death certificate be executed the burial-transit Physician/Medical esn for detached Completed by should be page 2 s director, Be ٩ the funeral Certification: After death.

Examiner Box 68760. Hospital or Attending after death. filled in by within 24 hours a To the Funerel C Medical completely To the

5. Social Security Number 212-18-2456 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 WILSON BLVD. 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2∰No Yes, Give 1 Never Married 2 Married 1 Yes XX No Specify: Specify: WHITE 3√XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 SEAMSTRESS HOME DECOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MICHAEL LITZ ELIZABETH D. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY McLAUGHLIN - DAUGHTER 118 WILSON BLVD., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEM. PK. 12/30/2004 GLEN BURNIE, MD 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signature of Funeral Service Licens *KELLY JEREGORY HINK #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immedia Cause (Final disease or condition resulting in death) Septicenira Due to (or as a consequence of) Mellitrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Delrydati Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 TYes

P.0. Division of Vital Records,

6

State Registrar

Vnaemeka Agajelu DHMH 17 Rev 1/2001

25. Was case referred to medical examiner?

1 ☐ Yes 2 X No

27. Manner of Death 1 Natural

2 Accident

3 🗀 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title

Hospital:

investigation

6 Could not be determined

1 Inpatient

and manner stated.

Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature

nzian

4304 Mountain Road

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number 00 056 950

1 ☐ Yes 2 ☐ No

Pasadena Mo

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. UU4 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Year Car1 Norman Rhoten December 29, 2004 9:36 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Westminster Nursing Home Westminster Carroll If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) Months Devs 15 M 2□ F Yrs. Director 219-12-1619 80 March 7, 1924 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or frems 23s or 2s=-1=-2008. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Carroll Finksburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3008 Old Gamber Road 21048 Funeral U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: \$ 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Admiral Management 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Charles 2 Rhoten Ella Valentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Carl Wayne Rhoten 3008 Old Gamber Road Finksburg, Maryland 21048 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/4/05 Finksburg, Maryland Finksburg Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Jims Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of) Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list cunditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Nivision of Vital Records, P.O. Box 68760. Due to (or as a consequence of) After this certificate has been signed by the funeral director, page 2 should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 2 Be Completed 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 2 D No 1 Yes 1 ☐ Yes 2 ☐ No Kmon 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide 29a. Certifier Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as season.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar ERnesto

31. Dete filed (Month, Day, Year)

Mendoza

JAN 0 3 2005

32. Registrer's Sign

680

			1 - For State Registrar	State of Ma		partment e <i>rtificate</i>			and M		iene eg. NO 🕜		11507
	Physici	an	1. Decedent's Name (First, Middle, Last)	0001						2. Date of Dear Month	\rightarrow	Year	3. Time Death
	/Medi	cal	Elsie May Repr			4h City 1	Tours or	Location of		Decembei		2004	9:42 A M
1	Examir	ier	1063 Parksley Ave			Balt			n Death			nty of Deat /a	n
	Funeral Director		5. Social Security Number 6. Sex 216–28–1256		(In yrs. last birthda 75 Yrs.	Months	1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day, Aug 18,	^Y 1929	9. Birtl Co Ma:	nplace (State or Foreign untry) ryland
	yland		10a. State 10b. County	T	10c. City, Town or	Location							10d. Inside City Limits
	e Mar 3a-f st	Director	Maryland n/a		Baltimo	re							1 Yes 2 No
	th with th	al Dire	106. Street and Number 1063 Parksley Avent	ue		10f. Zip (Code 1223	3		1	0g. Citizen d U1		untry? States
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is markad other than "natural", or Items 23a or 28a-1 show or other traumatic avant, the Medical Eventiner must be routhed as	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		3. Was Decede If Yes, speci 1 \(\text{Yes} \) 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		lack, White	nican Indian, o, etc. nite
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Gi	cedent's Usual ve kind of work . DO NOT use	l Occupa k done d e retired,	ition luring most)	of worki	ng	16b. Kind of	Business/l	ndustry
121	filed w Hygier othar th		17. Father's Name (First, Middle, Last)		Ca	shier		19 Motho	do Noma	/First Adiddle A		urant	t
ylan	should be and Mental is marked o	To Be	Edward Shupe					1	May S	(First, Middle, M Shumate			
	and 2 sheath and m 27 is n		Raymond Reprogel /		1063	Parks	ley		æ, I	Route Number, Baltimor			
Baltimore,	Pages 1 nent of H ant: If ite ury or otl		20a. Method of Disposition 1	emoval from State	20b. Place of Dis cemetery, c Oak Grove	rematory or oth	her place	. Cem.			20c. Location Church		own, State Maryland
Balt	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service License							bard Fu Balti			, Inc. land 21229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Phe Cum	onsequence of):	enter the mode		g, such as o					Approximate Interval Between Onset and Death Common Commo
68760,	certificate be executed rding physician and use as the bunal-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.		consequence of):								
.O. Box	death e atter d for u	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pre						Date of deliver	very Day Year
rds, P	The law requires that the tee has been signed by the sage 2 should be detache		Part II. Other significant conditions cont D() Clemente	4	not resulting in the	underlying ca	use give	n in Part I.			_		the cause of death?
Vital Record		Completed by							_	24a. Was ar autopsy perform 1 Yes 2	,	prior to co death?	opsy findings available ompletion of cause of
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	spital:	2 ☐ ER/Outpati	20 004	Othe			(Check only one			70 see p. c.
Division of	무 는 la	ation: To	27. Manner of Death 1 Natural 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time		c. Injury Work	4 🗀 IVU	2	ne 5 Tesider 8d. Describe how		ther (Speci urred	fy)
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, s (Specify)	street, factory,	office		2	8f. Location (Str. City or Town,	eet and Num State)	nber or Run	al Route Number,
	To the Hospital or within 24 hours after to the Funeral Discompletely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physical Cardinal Examination	cian: To the best of er: On the basis of e and manner state	kamination and/or	ath occurred at investigation, i	t the time	e, date and inion, death	place, a	nd due to the cand at the time, da	use(s) and n te and place	nanner as s , and due t	stated. o the cause(s)
)	To the within 2 To the complete	Ž	29b. Signature and title of certifier Sum 1 MML	mo At	tendy \	29c.	License 2(number 86	1	29	d. Date sign	ed (Month,	Day, Year)
	9		30. Name and address of person who com Bruce R. McCurdy I		th (Item 23a) (Type niden Cho	e, Print)	ne S	uite	101	Baltimo	re, Ma	arylaı	nd 21228
	Sta Registr		31. Date filed (Month, Day Year) 3 20	05 32. Flegistrar	Signature	parke)						

			1 - For State Registrar	State of Ma	aryland	l / Depa	artment of F	leaith a Death	and Men		ene20	04	41598
	Physici	an	1. Decedent's Name (First, Middle,	,				_		Date of Death Month		Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	Marion Oakl	Ley Ro	odgers	4b. City, Town, o	r Location o		ecember	28, 2		10:55 A ^M
	Examir	er	Montgomery Ho		7 Hous	20	-	Rockv			1	lontgo	mern
	Funeral			S. Sex 7. Age	e (In yrs. la.	st birthday)	If Under 1 Year Months Days		24 Hrs. 8. [Date of Birth Month, Day, Yo			ce (State or Foreign
	Director		160-01-0057 Usual Residence of Decedent	1□M 2\ F	88	Yrs.		110010	Ma	y 22, 1	1916		nsylvania
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation	<u> </u>				10d	I. Inside City Limits
	e Mar	ctor					Wash	ingto	n, D.C				1 X Yes 2 □ No
	with th	Director	10e. Street and Number				10f. Zip Code				. Citizen of W	hat Country	1?
	eath v	Funeral	6838 6t	th Street N.		13 \	Vas Decodent of H	200		Voc or No		ted S	tates
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Mcdical Examiner must be notified at	Fun	1 Never Married 2 Married	Armed Forces? d 1 ☐ Yes 2 🕅 N		1	Vas Decedent of H I Yes, specify Cuba		n, Puerto Rica	n, etc.)		, White, etc	
Maryland 21215-0036	ural',	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:				Specify:			Specify:	W	hite
7	in 72 l	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual Occup kind of work done o DO NOT use retired	during most	t of working	16	b. Kind of Bus	iness/Indus	stry
212	d with giene. rr thar	mo	Elementary/Secondary (0-12)	College (1-4or 5	+)			naker			0	wn Ho	me
2	al Hyg d otha	Bec	17. Father's Name (First, Middle, La	ist)					er's Name (Fin	st, Middle, Mai			mc_
Уa	ould to	P		rence D. Oa	kley						Palmer		
Mai	d 2 sh th and th is m traum		19a. Informant's Name/Relationship				g Address (Street						
ē,	f Heal frem 2 item 2		Doris O. Taylor/ 20a. Method of Disposition		20b. Pla	ce of Dispos	ngsbridge sition (Name of natory or other place	Road	d Rehot	oth Be	ach D c. Location - C	elawa ity or Town	re 19971 n, State
altimore,	Page nent o ant: if ary or		1 X Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe				k Cemete	rv :	Januar 8, 200	Y.	Washi	neton	D.C.
Balt	permit. Pages. Department of H Important: If Ite any injury or of		21. Signature of Furneral Service Lie	censee		Re Re	Name and Addre	ss of Facility	y Robert	TRC 7	mphrey	Fune	ral Home/ in Avenue
	σΩ≒ e ol		23a. Part1. Enter the disease, or co		M0033	5 Be	thesda, 1	Maryla	and 208	314-350	1		
	Dharatatan 1		shock, or heart failure. List or Immediate Cause (Final	ity one cause on each lin	0. Oeaun.	Do not ente	er the mode of dyin	g, such as	cardiac or res	piratory arrest,	•	ln!	pproximate iterval Between inset and Death
	Physician /Medical		disease or condition resulting in death)	a. Lung C						_		M	onths
	Examiner	П	Sequentially list conditions	b									
	ed tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	a conseque	nce of):							
	and al-tran	Examiner	Cause (Classes or Injury that initiated events resulting in death) Last	c Due to (or as a	conseque	nce of):						-	
8760,	icate be executed physician and s the burial-transit	dlcal		d									
9	artifica ing ph e as th	Med	IF FEMALE:										
Вох	death certific e attending p id for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth	2 Fetal d	eath 3	Ectopic pregnancy				23d. Date Mont	_	ay Year
o.	0 00	nyslo	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4□Pregnant at t 9□ Unknown	time of dea	tn 5∟	Other (specify)						,
a,	The law requires that the te has been signed by throage 2 should be detached.	by P	Part II. Other significant conditions	s contributing to death bu	it not resulti	ng in the un	derlying cause give	en in Part I.		23e. Did tobac	co use contrib	ute to the o	cause of death?
ğ	equire sen sig ould b	ted t								1 X Yes	2 □ No 3	Probabi	y 4 🗆 Unknown
Hecords,	has be	Completed								24a. Was an autopsy	pri	or to compl	findings available letion of cause of
-			OF Management to accept the							performed ☐ Yes 2 🔀		ath? Yes 2	□ No
Ē	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatier	nt 2∏ FE	VOutpatient	3C DOA Othe		of Death Che		e Mother	(Canaita)	Hospice
Ö	ding Ph		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	y 2	8b. Time of Injury	28c. Injury Work	at	28d. I	Describe how in	njury occurred	(Specify)	ноѕрісе
S	Attandide death.	catle	2 Accident investigat	be			M 1 []	Yes 2□N					
Division of	after of Direct in by	Certification;	4 Homicide determine		ry - At hom. . (Specify)	e, farm, stre	et, factory, office		28f. L	ocation (Stree City or Town, S	t and Number tate)	or Rural Re	oute Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 🛣 Certifying	Physician: To the best of	f my knowle	edge, death	occurred at the tim	ne, date and	d place, and d	ue to the cause	e(s) and mann	ner as state	d.
	the Ho	Medical	(Check only 2 Medical Ex	aminer: On the basis of and manner stat	examination	n and/or inv	estigation, in my of	oinion, deatl	h occurred at	the time, date	and place, an	d due to the	e cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier				29c. License	number		29d.	Date signed (Month, Day	y, Year)
	n I		20 Name and address of a son	100	oth /! 7	20) (7		3R4216	5114	1	Decembe	er 29	, 2004
	10		30. Name and address of ron Chitra Rajawpal,					Rock	vi11_	Marvil	and 200	355	
	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signatur	θ /	will noac	. NOCK	·V IIII e	Haryre	411U 2UC	درر	
	Registra	ar	JAN 03	LUUD BLAR	s st	149	-						

			1- State of Maryland / D		rtment of He tificate of D			giene leg. No. 200	4 41599
	Di vivi		Decedent's Name (First, Middle, Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medic		Natalie W. Rothenberg					r 26, 200	
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L	ocation of Death		4c. County of De	eath
			2900 N. Leisure World Blvd.			er Sprin		Montgom	
п	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	(, Year) 9. E	Birthplace (State or Foreign Country)
			577-36-3270 75 Usual Residence of Decedent	1			October 1	.9, 1929 Was	shington, D.C.
	rylan how	_	10a. State 10b. County 10c. City, Town	or Loc	cation		-		10d. Inside City Limits
	Ba-f s	cto	Maryland Montgomery Silver	Sp	ring				1 ☐ Yes 21X No
	vith th	Director	10e. Street and Number		10f. Zip Code		1	log. Citizen of What	Country?
	sath v	erai	2900 N. Leisure World Blvd. 11. Marital Status 12. Was Decedent Ever in U.S.	12.1/	2090	<u> </u>		United Sta	
10	ter de ritem Ineri	Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	ls. V	Vas Decedent of Hisp Yes, specify Cuban,	, Mexican, Puerto I	Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
036	urs a	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2 🖾 No	Specify:		Specify: T	White
21215-0036	72 hours after death with the Maryland neturel; or items 23a or 28a-f show Alcal Examitrate the molified at	Completed	15. Decedent's Education (Specify only highest grade completed)	Deced (Give	ent's Usual Occupati	ion vina most of worki	na	16b. Kind of Busines	ss/Industry
2	within ene.	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired)		,9		
2	e filed within al Hygiene. I other then " vent, the M.		17. Father's Name (First, Middle, Last)		Cartogra	pher 18. Mother's Name	(Einst Middle	Federal (lovernment
Maryland	td be f ental h ked of	Be c			'		,	,	
<u> </u>	2 should be and Mental Is marked raumatic ev	은	Douglas A. White 19a. Informant's Name/Relationship (Type, Print) 19b.	Mailin	g Address (Street an		Zimmer	L1 r, City or Town, State	. Zip Code)
	5 = 2 t							cus, Maryl	
altimore,	es 1 and 2 of Health fitem 27 r other tr		20a Method of Disposition 20b. Place of I	Dispos	sition (Name of	D	ate	20c. Location - City	
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) Crema	iont	atory or other place) gomery ium, Inc.	Decemb 200	er 31,	Bethesda.	Maryland
alt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Puneral Service Licensee	22.	Name and Address	of Facility Robe	ert A. 1	Pumphrev I	Tuneral Home/
8	20 5 6 3		M01405	Ro	ckville,	Maryland	20850 Me	ontgomery	Avenue
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot ente	or the mode of dying,	such as cardiac o	respiratory arr	est,	Approximate Interval Between Onset and Death
	Priysician	1	Immediate Cause (Final disease or condition resulting in death)	N	to the	a/ 1/	Min		Onset and Death
	/Medical Examiner		Due to (or as a consequence of	of):					/
		ē	Sequentially list conditions, if any, leading to immediate b.	or).					
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	·					
ó	an an rial-tr		resulting in death) Last Due to (or as a consequence of	af):					
8760,	death certificate be executed e attending physician and d for use as the burial-transit	edicai	d						
9	ertifica ling pl	Med	IF FEMALE:						
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of d	elivery Day Year
o.	that the de ed by the detached	Physician/M	1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 9☐ Unknown	5□	Other (specify)				
<u>α</u>	The law requires that the to has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but no resulting in	the un	derlying cause given	in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
rds	quires in sign	ed by	Madely Mellilin				1 □ Y€	es 2 1 No 3 □ 1	Probably 4 Unknown
000	aw requir is been si 2 should I	piet					24a. Was a		autopsy findings available
Vital Records,		Completed					autops perform		
/ita	vsictan: Th	Be	25. Was case referred to medical examiner?		2	26. Place of Death			
of V	hysic this co	은	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp			4 Nursing Hon		ence 6 Other (Sp	ecify)
n c	ding Ph h. After th funeral	ion:	Terratural Solit Griding	ime of njury	28c. Injury a Work?		8d. Describe ho	w injury occurred	
Division	Attending Physiclan: r death. ector: After this certific by the funeral director.	licat	2 Accident investigation 3 □ Suicide 6 □ Could not be determined 28e. Place of Injury - At home, farm	m stre		s 2 No	8f Location (St	reet and Number or I	Rural Route Number
Ω	after Direct	Certification:	4 Homicide determined building, etc. (Specify)	m, stro	ot, ractory, office		City or Town		idiai riodie radrioer,
	To the Hospitel or Attentwithin 24 hours after dealing to the Funerel Director: completely filled in by the		29a. Certifier 12 Certifying Physician: To the best of my knowledge,	, death	occurred at the time,	, date and place, a	nd due to the ca	use(s) and manner a	as stated.
	he Ho in 24 I he Fu pletely	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	Vor inv	estigation, in my opin	nion, death occurre	d at the time, da	ate and place, and du	ie to the cause(s)
	To t To t	Ž	29b. Signature and title of certifier		29c. License n	number 1/	29	9d. Date signed (Mor	nth, Day, Year)
•	11		190 mm 190		VL	5 10		December :	29, 2004
	20		30. Name a dress of person who completed cause of death (Item 23a) (T		-				
			Joey Schulman, M.D., 6000 Executive 31. Date filed (Month, Day, Year) 32 Registrar's Signature			300, Rocl	kville,	Maryland	20852
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2005	Los	West .				
				_					

An1	tho	ny F. I	Ret	taliata Jr. Please	Type or Pri	nt in Blac	ck Ind	delible Ink.	Ensure A	II Copies	s Are	Legible.	
AGI				1 - State Unpend Item Registrar	State of Ma	arviand /	Dena	rtment of H	lealth and M	Mental Hy	/gien Reg. M	е	1.1600
		Physici	an	1. Decedent's Name (First, Middle, La						2. Date of De		ay Year	3. Time of Death
		/Medic		Anthony Franc			,			Decemb		27, 2004	5:54 P ^M
		Examin	er	4a. Facility Name (If not institution, gir				_	r Location of Death	1	40	c. County of Dea	th
- Company				I-70 west @ Patap				Ellicott				Howard	
ומר		Funeral Director			Sex 7. Ag	e (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da Sept.	a <i>y</i> , Yea <i>i</i>	r) Co	thplace (State or Foreign buntry) MD
		land		10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
		Mary f sh	to	MD Baltimo	re	Tin	noniı	ım					1 Tes 2 No
		r 28a	rec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Co	
		3a o	Funeral Director	1 Bedwell Ct.				2109	3			USA	
		death ms 2	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No	0-	14. Race - Ame	
	9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces?	No		_		o Hican, etc.)		Black, Whit	
	8	rel', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			☐Yes 2☐No	Specify:			Specify:	white
	Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. If health and Mental Hygiene, and the man 27 is marked other then "naturel", or litems 23a or 28a-f show inter 27 is marked other the "naturel". Other treumetic event, It a Maritial Examirer must be notified at	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)			(Give k	ent's Usual Occup kind of work done o OO NOT use retired	during most of world	king	16b. l	Kind of Business	/Industry
	7	er th	Son	12	4	C	ompu	iter Soft	ware Sal	es		Comput	er
	p	al Hy	Be (17. Father's Name (First, Middle, Las	")				18. Mother's Nam	ne (First, Middle	, Maide	n Sumame)	
	yla	Ment Ment arke	2	Anthony Francis	Rettaliata				Margare				
	a	2 sho and Is m	11	19a. Informant's Name/Relationship					and Number or Ru				Zip Code)
	≥ .	and ealth n 27		Linda J. Rettalia	ita/wife				., Timoni				
	ore	of H of H if iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place cemet	of Dispos ery, crem	sition (Name of atory or other place	(a)	Date	20c. L	Location - City or	Town, State
	Ē	Pag ment ent: ury c		4 ☐ Donation 5 ☐ Other (Speci		Balto	. Wa	ash. Cre	ematory 1	/5/05	L	aurel, N	1D
	Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot once.	1	1. Signatur U Fu Joral Service Lica	nsen D		22.	Name and Addres	ss of Facility	omo of	Dud	anav Va	llov lpo
	_	20 E 29		Lowell M. Le	mmon		10	W. Pade	onia Rd.	Timor	nium	MD 21	lley, Inc. 093
•		Physician /Medical Examiner		23a. Pant. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	ne.	ardio	Ź	g, such as cardiac		irrest,		Approximate Interval Between Onset and Death
		יַּבּ פֿ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	e of):						
		xecuted and al-transii	xaminer	Cause (Disease or injury that initiated events resulting in death) Last	c								
	0	e exectan a	ш	(esulting in death) cast	Due to (or as	a consequence	e of):						
	876	ate b hysic the b	lica	•	d								
	P.O. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			ř	23d. Date of dei Month	ivery Day Year
	<u>Р</u>	res that the signed by to be detach	Ph.	9 🗆 Unknown						00. Ditt			the cause of death?
		res th	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.		Yes 2		V
	010	v require been si should l	Completed							14	165 2	2 UNO 3 UF	ODADIY 4 MOTIKIOWIT
	ec	taw tas b	Jple							24a. Was auto	psy	24b. Were au	topsy findings available completion of cause of
	Œ	The law cate has page 2 s	Con							1 Yes	ormed?	o death?	2 🗌 No
\	/ita	iiclen: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place of Deat	th (Check only o	one)		
À	Ž	S S P	2	1 XYes 2 No	Hospital: 1 Inpatie	ent 2 ER/O	utpatient	3□ DOA Oth	er: 4 Nursing Ho	ome 5 Resi	dence	6 Other (Spec	oify) at scene
	u u	ling Phys The After this tuneral di	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b.	Time of Injury	28c. Injun Worl	K?	28d. Describe	how inju	ury occurred	
	Sio	Attending Physicien: r death. ector: After this certifica by the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not to					Yes 2 No				
	=	or Att	Certification;	4 Homicide determined		ury - At home, i c. <i>(Specify)</i>	farm, stre	et, factory, office		28f. Location (. City or To	Street ai wn, Stat	nd Number or Ru 'e)	ıral Route Number,
		To the Hospitel or Attending Ph within 24 hours after death. Lp the Funetel Director: After th completely filled in by the funeral	Medical Co	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination a	ge, death ind/or invi	occurred at the timestigation, in my of	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s date an	s) and manner as nd place, and due	stated. to the cause(s)
_		To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License	e number		29d. Da	ate signed (Monti	h, Day, Year)
	-	101) (a + NO HA	elau n	A		O.C.M	.E.	T)ece	mber 28,	2004
		XX		30. Name and address of person who) (Type F						2 00-F
	1	120		CAROL H. AL	Awned		11		treet, Ba	altimore	e. M.	arvland	21201
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MES	ROBINS		For State Registrar		State	e of Ma	aryland		artmen rtificat			and M	lental Hy	giene Reg. Ne	$2 \Pi \Pi$	1.3	L. I	601
	Physici	an	1. Decedent's Name		.ast)								2. Date of De Month DEC •		-	ear		of Death
	/Medic	al		obins	ive street an	d number)			4h City	Town or	Location	of Dogth	DEC.				210)4 P M
	Examin	er	4a. Facility Name (If I HARFORD	MEMORIA	L HOSE	PITAL			HÄt	ÆË D	E GR	ACE"		40	HARF	ÖRD		
	Funeral Director		5. Social Security Nur		Sex 15 M 2□		e (In yrs. lasi 4	t birthday) 4 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Sep 2,	ay, Year)		Birthpl Coun ID	ace (State try)	e or Foreign
	and		Usual Residence of E	Decedent 10b. County			10c. City, T	Town or Lo	cation		-					10	Od. Inside	City Limits
	Marylan f show	ō	MD	Harfor	d				Grace	9								9S 2 00
	r 28a	Director	10e. Street and Numb				11411	- 40	10f. Zip					10g. Ci	tizen of Wha	t Coun	try?	
	th with	al D	Unknown						210	58				Uni	ted St	tate	es	
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and	d be file ental Hy ked oths c event,	To Be C	17. Father's Name (F James Ro	First, Middle, La Obins	st)								(First, Middle					
ary	shout nd Me s mark umati	F	19a. Informant's Nan		(Type, Print,)		19b. Mailir	ng Address				I Route Numb			te, Zip	Code)	
ž	and 2 salth a 127 is		Tammy Smi	th/Sist	er			490 M	lain S	Stree	t #22	22, V	Vasilla	ı, Al	9965	4		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Is marked other their neturel, any injury or other treumatic event, I'm Medical Era page.		20a. Method of Dispo 1 Durial 2 S 4 Donation 5	Cremation 3		from State	cem	etery, crer	sition <i>(Nan</i> natory or o ke Cr	ther place	'	D	ec 31		ocation - City			
Balti	permit. Departrr Importa any inju		21. Signature of Fund	eral Service L	Insee C	1	10098	6 22	Name an	d Address	of Facility and	y Fune ture	ral Alt s Drive	tern	atives	i	MD	
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	/Medical Examiner		resulting in death)	4	Du	e to (or as	a consequen	ice of):				-						
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rds, P	w requires that the been signed by the should be detache	by	Part II. Other signific	cant conditions	contributing	to death be	ut not resultir	ng in the ur	nderlying ca	ause givei	n in Part I.		23e. Did t		use contribut			death?
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/ita	Physicien: Th r this certificate ral director, pag	Be (25. Was case referre examiner?	ed to medical	Manaital							of Death	(Check only o	one)				
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Division of Vital	Attendi	Certification:	3 Suicide 4 Homicide	6 Could not	be 28e. F	Place of Inju	ury - At home c. (Specify)		-		T		8f. Location (Street an				
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	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 (Check only 2 one) 2	Certifying	aminer: On t	o the best of he basis of manner sta	examination	dge, death and/or inv	occurred a restigation.	at the time in my opi	e, date and inion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) date and	and manne I place, and	r as sta due to	ted. the cause	(s)
	To the within 2 To the complet	Σ	29b. Signature and til	itle of certifier	18 101	1/21/	ul		29c	O.C	.M.E			29d. Dat	e signed (M EC. 2	enth, D	ay, Year) 2004	
	3		30. Name and address	ss of person wh	o completed	cause of d	eath (Item 23	Ba) (Type, PENN	Print) STRE	ĒΤ,	BALTI	MORE	,MARYL	AND	21201			
	Sta Registr		31. Date filed (Month		2005	32. 1	r's Signatu	1	2041	-								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10:05 AM ber 30, 2004 Franklin S. Rather /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1937 Steven Drive Harford Edgewood If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 1 M M 2 □ F 70 Director 219-28-4426 Aug 15, 1934 West Virginia Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County in than "naturel", or items 23a or 28e-f show the Madical Examinar must be notified at 1 Yes 2 No Director MD Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21040 United States 1937 Steven Drive 12. Was Decedent Ever in U.S. Amed Forces? 1 Deves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Aerospace Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ada Catherine Hull Franklin S. Rather 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deloris Rather/Wife 1937 Steven Drive, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec 31 2004 Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee W 2 8717 Green Pastures Drive 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oropharyngeal /Medical Due to (or as a consequence/of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medica IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by th ? should be detache 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No certificate Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E1kton M1) 21921 Slagons 31. Date filed (Month, Day, Year) State JAN 0 3 2005 Registrar

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			1 - For State Registrar	Otato o. ma	,		rtificat				-	Reg. No.2	nn	1. 1.1000
			Decedent's Name (First, Middle, I	ast)							2. Date of De		Yea	3. Time of Death
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				Sex 7. Age		last birthday)	If Under		1camp		8. Date of Birt		400.	Ord
	Funeral Director		213-36-3954	10M 20F	71	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Sirthplace (State or Foreign Country) aryland
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	show	'n	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2√ No
	the M	ecto	WV Ra.	leigh			Beav 101. Zip					10g. Citizen	of What	
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98	or Its	y Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ N If Yes, Give	lo		1 ☐ Yes	**	Specify:		ilicari, otc.,			White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a Dece	dent's Usua	al Occupa	ation			16b. Kind		ss/Industry
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п			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	the death									Approximate Interval Between
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	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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Δ.	s that ned by a deta	y Pr	Part II. Other significant conditions	contributing to death be	it not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco use	contribute	to the cause of death?
rds	quires en sign uld be										1 🗆 1	∕es 2□N	lo 3 🗆	Probably 4 dinknown
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DO	ding h. After funer	tlon	1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	Injury	M	8c. Injury Work	rai (? Yes 2 □:		.og. Describe r	iow injury oc	Zumeu	
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	To the Hospital or Attending Phwithin 24 hours after death. To tha Funaral Diractor: After th completely tilled in by the funeral	Medical	one)	and manner sta	ted.	and and or in								
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	Regist	rar	JAN 0 3	2005		• .	Lack.							

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			1 - For State Registrar	State of Ma	arylan		artment rtificate				ental Hy	giene	001	+ L;	1604
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las Irma Rivera								2. Date of De Month	eath Day	Ye 30 20	ar CV	Time of Death ろ・5つ pM
	Examir	er	4a. Facility Name (If not institution, give	street and number)	r A. R	E	4b. City,		Location of		6	4c.	County of D		
	Funeral Director		5. Social Security Number 6. Se			ast birthday) Yrs.	If Under Months		If Under Hours		8. Date of Bi (Month, D. Nov. 1	av. Year)	9.	Birthplace	(State or Foreign
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County			,Town or Lo	ocation							1	nside City Limits Yes 2 \(\bigcap \) No
	th the M	Funeral Director	MD 10e. Street and Number		Dair	TINOTE	10f. Zip	Code				10g. Citi	zen of Wha		<u></u>
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	nysician /Medical		23a. Part. Enter the disease, or companies, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each li a	ne.		er the mode	e of dying	g, such as	cardiac o	r respiratory a	arrest,		Onse	roximate val Between et and Death
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8760,	ate be executed hysician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of).	<u>e d e</u>	mo						UN	1cn own
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	déath 3 🗆	Ectopic pre			-		2	23d. Date of Month	delivery Day	Year
S, D	es thai igned t be det	by P	Part II. Other significant conditions of			_	nderlying ca	ause give	n in Part I.		1				use of death?
ord	w require been si should I	eted	END STALLE R	ENAL ;	AIL	URE					-	Yes 2			4 DUnknown
		Completed									1 Tes	psy ormed? 2 No	24b. Were prior death	to complete	ndings available on of cause of No
Κ	Physician: this certifice ral director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2∏1	ER/Outpatien	it 3□ DO.	A Othe			(Check only ne 5□Res		Other (9	necity)	
ion of	Jing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work	at	2	28d. Describe			респу	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, str	eet, factory,	, office		2	28f. Location (City or To	Street and wn, State)	d Number of	r Rural Rou	te Number,
	he Hospi in 24 hou he Funer pletely fill	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exem	ysicien: To the best iner: On the basis of and manner sta	f examinat	wtedge, death ion and/or in	n occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, a th occurre	and due to the ad at the time,	cause(s) date and	and manner place, and	r as stated. due to the c	cause(s)
	You To T	Z	29b. Signature and title of certifier	Pesal	aN	avee	v) 29c.	License	number	15		29d. Date	e signed (M	onth, Day, \	Year)
	2		30. Name and address of person who a NWVEEN RESUL	7 completed cause of d	leath (Item	23a) (Type,	Print)	, 60	alti	m d	re MI	0-2	2122	9	,
	Sta	- 120	31. Date filed (Month, JAN) 3	2005 32. Revistr	ar's Signat	ure	boarde	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROTHS **Physician** BUNGSI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A 1 hai 8. Date of Birth Month Day, year FEB. 2, 1917 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 🛣 F MD 87 Director 215-10-6754 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or itama 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 21208 USA 7503 PARK HEIGHTS AVENUE Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No WHITE Specify: Specify: 3 ☐ Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNIV OF MD LAW SCHOOL SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F is marked of Pages 1 and 2 should be LEVIN **ESTHER** BAER LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i 3415 MIDFIELD ROAD - BALTIMORE, MD 21208 RUTH HOLLANDER / SIS-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State to = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of important: If any injury or once. ARLINGTON CHIZUK AMUNO 12/31/2004 BALTIMORE, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death TUMOR Immediate Cause (Final BRAIN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examiner the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ INTRACRAMIAL HYPERTEMION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CERERRAI 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy DIOPLILMONAR 1 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 noatient Other: 2 1 Yes 2 No. 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural after death. 1 Tes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 \(\text{Homicide} 24 hours a 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical mpletely (Check only one) in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 19c License number 29d. Date signed (Month, Day, Ye 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year)

30. Name and address of person

PARK 32. Registrar's Signature

JAN 0 3 2005



PUENUE

HTS

of death (Item 23a) (Type, Print)

-84 -	∔ ±4		1 - State Unpend Item 2	State of Maryland	d/Depa	utment of J	lealth and 8-05, tas	Mental Hygi	ene 2001	1.1606
	_a		Registrar 1. Decedent's Name (First, Middle, Last,		Ce	uncate of	Dealli	2. Date of Death	1	3. Time of Death
	Physici /Medi		CHARLOTTE	MICHELLE	= 5			December	1	
	Examir	er	4a. Facility Name (If not institution, give 1910 H Edgewater 1			Edgewood	or Location of Dea	th	4c. County of Dea	ith
ğ	Funeral Director		5. Social Security Number 6. Se:		ast birthday) Yrs.	If Under 1 Year Months Days			Year) 9. Bi	nthplace (State or Foreign ountry)
			Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation		1,101.30		10d. Inside City Limits
	the Marylan r 28a-f show	tor	11	ORD	E	DGEW	000			1 Tyes 2 No
	with the M	Funeral Directo	10e. Street and Number			10f. Zip Code	7 : :	10	g. Citizen of What C	ountry?
	death with ms 23a or	neral	1910 EDGE	WATER DRI		Was Decedent of I	Hispanic Origin? (Specify Yes or No- to Rican, etc.)	14. Race - Am	
36	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show utsal Examilies of usit be rediffed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2.▼No If Yes, Give		iYes, specify Cub 1 □ Yes 2 🖄 No	Specify:	to Rican, etc.)	Black, Whi	te, etc.
5-0036	72 hours "natural",	ted t	15. Decedent's Edu (Specify only highest grad	Year or Dates:	16a. Dece	dent's Usual Occup kind of work done	pation	orting 1	6b. Kind of Business	Vindustry
2121	C * T	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		S	to me
d 2	ba filed withir vial Hygiene. Id other than avant, the M	Be Co	17. Father's Name (First, Middle, Last)			(OTTIE	18. Mother's Na	me (First, Middle, M		TOME
Maryland	2 should ba filed withir and Mental Hygiene. is markad other than aumatic avant, Ita Ma	To	CHARLES		-WAI		NAO	MI	PETER	SON
	5 5 5 E		19a. Informant's Name/Relationship (Ty JENIEN JONES	(DAUGHTER)	100	A 1 010			City or Town, State,	Zip Code) MD 21040
Baltimore,	0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	ace of Dispo emetery, crei	sition (Name of natory or other pla	сө)	Date /2	0c. Location - City or	
Iţi	it. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furieral Specice Licens	MJ	ZION	CEMETE Name and Address	ERY 0/-	03-05/	ANSDOWN	IS MARYLAND
Ba	permit. Departm Importa any inju		Sow	M	×	19400.	FULTO,	NAVE. &	JR. Fa.	10 21217
			23a Part1. Enter the disease, or complete Shock or heart failure. List only or	ications that caused the death ne cause on each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ		ation				
	Examiner	.	Sequentially list conditions, if any, leading to immediate	b	,					
	utad d ansit	Examiner	Cause (Disease or injury	Due to (or as a consequ	ience of):					
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687	ficate be p physicial ts the buri	edical		d	-					
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P.O. I	it the dea by the a lached fo	ysici	1 ☐ Yes 2 ☐ No 9 🖼 Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (specify)			Month	Day Year
	res that igned b		Part II. Other significant conditions cor	ntributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.			the cause of death?
cord	w require been si should b	eted								robably 4 Unknown
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Division of Vital Records,	Attanding Physician: The death. actor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		t 3 DOA Oth		ath (Check only one)	
of	g Phys er this ieral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	I JUDOA	4 🗀 Rui Sing r	dome 5 Resident	ice 6 Other (Spe v injury occurred	unk
sior	ittanding l death. ctor: After / the funer	catlo	1 □Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 ☑ Could not be	12-28-04	Found: 4:48	P ^M 1□	Yes 2 No			
Divi	af or Al s after o I Dirac d in by	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ★ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify) Found:Reside)	et, factory, office	1	28f. Location (Stre City or Town,	et and Number of Ri State) 1910H Iarford Co	Edgewater Dr.
	To tha Hospital or Atta within 24 hours after de To tha Funaral Diract completely filled in by th	edical C	(Check only 2 Medical Examil	sician: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the tir	me, date and place	and due to the cau	ise(s) and manner as	stated
	To tha within 2 To tha complet	Med	29b. Signature and the of certifie	and manner stated.		29c. Licens			d. Date signed (Mont	
	, , , , , , , , , , , , , , , , , , ,		HICH	100		OCMI	E	De	cember 29	, 2004
			30. Name and address of person who co	ompleted cause of death (Item			ceet Dol+		ryland 21	
	- Sta		31. Date filed (Month, Day, Year)	82. Registrar's Signat	uro 4		eer Dall	лиоге, ма	TATAIM 71	201
	Registr	ar	JAN 0 3 2005	Sien &	A					

CKEVE	ETT SEYM	IOU	R 1 - State Unpend Item 23	State of Ma Per	rylan ne	es Es Cer	rtgen tificate	5 ^{of} La	galth a Death	and M	ental Hy	giene	2001	. 416	07
	Physicia	an	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	ath Day	Ye	3. Time of	
	/Medic		McKevett			Se	ymour				DEC.		2004	0820	A M
	Examin	er	4a. Facility Name (If not institution, give st 95 SPRINGTIME WAY				PAR	KVII				В	ALTIM	ORE	
5	Funeral Director		5. Social Security Number 6. Sex 214–17–6165	M 2□F	(In yrs.) 27	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da		9.	Birthplace (State of Country)	r Foreign
3			Usual Residence of Decedent								9-25-	.//		Md.	
	h the Maryland r 28e-f show	<u>_</u>	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Cit ¶∑ Yes	
	the M	Director	MA NA			Park	ville					10a Citis	zen of What		
	with 9e or			217				21234	1			rog. On	USA	Country	
	death ms 20	Funeral		2. Was Decedent E	ver in U.	S. 13. y				igin? (Spe	cify Yes or No Rican, etc.)	0-	14. Race - A	American Indian,	
36	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show edical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates:	0		rYes,spec I⊡Yes 2				Hican, etc.)		Black, V Specify:	white, etc. Black	
0.0	72 hou		15. Decedent's Educi (Specify only highest grade	ation		16a. Deced	lent's Usua	I Occupa	ition	t of worki	2	16b. Kir	nd of Busine	ess/Industry	
21	E . E	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	+)		kind of wor DO NOT us)	I OI WOIKII	<i>'</i> 9				
2	a filed wit Il Hygiene othar the vant, the		11th grade 17. Father's Name (First, Middle, Last)			<u> </u>	isabl	.ed	18 Mothe	are Namo	(First, Middle	Maiden	NA		
Baltimore, Maryland 21215-0036	d ta b e	To Be	Kenneth	М.	80	vmour				Cyntl		, Waluell	,	ones	
ary	ds D III	F	19a. Informant's Name/Relationship (Typ		De		g Address	(Street a		_	l Route Numb	er, City or			
Ξ	1 and 2 Health a tam 27 Is		Cynthia Seymour	Mother		95	Spri	ngti	me W	ay, I	Baltimo	ore,	Md.	21234	
ore	of Hes of Hes if itam or otha		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. P	lace of Dispo- emetery, cren	sition (Nam natory or of	e of her place	e)	D	ate	20c. Lo	cation - City	or Town, State	
Ë	Pages Iment of tant: If it		`4 Donation 5 Other (Specify)		Ki	ng Mem				12-3				town, Md.	
Ball	permit. Pages: Department of H Important: If its any injury or of		21. Signature of Euneral Service Licensee	2 few	K	22	. Name and Marc		s of Facilit H. E				more, Nort	Md. 212 n Ave.	.02
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	8/1/8		Mayorte Un	· Soul	U	Mn		0.C.	M.E			DEC	. 26,	2004	
	Shy		30. Name and address of person who com	(COREW	111	PENN :	STREE	Т, В	ALTIN	MORE.	MARYLA	ND_21	1201		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 20	32. Pigistran	r's Signa	ture	rele	,				=	201		

			Please	Type or Prin				•	•	
			For State	State of Ma	ryland / Dep			vientai Hyg	iene noll	41608
			Registrar 1. Decedent's Name (First, Middle, La	oct)		ertificate of	Death	2. Date of Deat	g. No.	3. Time of Death
	Physicia	n		rong				December		12:19pm M
	/Medica Examine		4a. Facility Name (If not institution, gir			4b. City, Town, o	r Location of Death		4c. County of Dea	
			114 Lassiter Cir	cle		Finks	sburg		Carrol1	
	Funeral			TH OFF	(In yrs. last birthda) Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign puntry)
	Director		218-28-2366 Usual Residence of Decedent	73 × 73	113.			Oct. 26	, 1931 M	עו
	nylano how		10a. State 10b. County	1	10c. City, Town or I					10d. Inside City Limits
	Ba-f s	Ş	MD Carrol	.1	Fink	sburg				1 □Yes 2 No
	72 hours after deeth with the Maryland natural; or Items 23a or 28a-f show disal Examinat must be notified at	Funeral Director	10e. Street and Number 114 Lassiter Circ	10		10f. Zip Code 21048	2.	10	og. Citizen of What Co USA	ountry?
	ns 23	era	11. Marital Status	12. Was Decedent F	ver in U.S. 13	. Was Decedent of I If Yes, specify Cub		pecify Yes or No-	14. Race - Ame	erican Indian,
9	or iter	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0	If Yes, specify Cub	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
003	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	rear or Dates:					Specify: Wh	
7	n 72 h	lete	15. Decedent's E (Specify only highest gi	ade completed)	16a. Dec (Giv	edent's Usual Occup re kind of work done DO NOT use retire	ation during most of worl d)	king	16b. Kind of Business	/Industry
212	yiene.	E O	Elementary/Secondary (0-12)	College (1-4or 5-	+) 1	Teller	-,		Banking	
b	al Hyg I othe	Be Completed	17. Father's Name (First, Middle, Las	*			_	ne (First, Middle, N		
<u>Vla</u>	ould b Ment Marked	ို		Schmier			Iona	(Unkno		
Mar	d 2 sh th and 7 is rr traum		19a. Informant's Name/Relationship Mrs. Patricia Bud	• •					City or Town, State,	
อ์	tem 2		20a. Method of Disposition	Illian (Daug	20b. Place of Disp	position (Name of			20c. Location - City or	
E OE	Pages ient of nt: If i		1 ABurial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special Control of Cont			ematory or other pla n Cemeter		2005	Baltimore,	MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylann Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Expressionals be notified at once.	Ì	21. Signature of Funeral Service Lice	nsee/		22 Name and Addre	STOFFACILITY TERAT. HOM	E & CHAP	EL, PA. (B	ox 195)
8	89 2 2 9		Duan a.	Hay		Sykesville	e. MD 217	84 (410)	-795-1400	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that caused one cause on each lin	the death. Do not e e.				est,	Approximate Interval Between Onset and Death
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687				d						
XoX	th cer tendin r use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□Ectopic pregnance	,		23d. Date of de	
, O	the at	/slcl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at i 9□Unknown	time of death 5	Other (specify)			Month	Day Year
ď.	that the de ned by the s detached t	Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	w requires that been signed to should be det	g D	CANIASUN	<u> </u>				1	s 21 2 No 3□Pr	obably 4 🗀 Unknown
Ō	law rec as bee 2 shot	plete	()	•				24a. Was ar	24b. Were au	utopsy findings available
Re	sicien: The lav certificate has rector, page 2	Completed by						autopsy perform	ned? death?	completion of cause of
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?	Hansitali				th (Check only one	_	
of	ding Physicien: 7. After this certifice funeral director.	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatier	nt 2□ER/Outpation		4 🗆 radising m	ome 5 2 esider	nce 6 Other (Spe	cify)
no	Attending r death. actor: After	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	Wor	k? Yes 2 □ No	200.000100110	windry occurred	
Division of Vital Records, P.O. Box 68	l or Attendate death Director:	Certification;	3 Suicide 6 Could not determined	28e. Place of Inju	ry - Al home, farm, s	street, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
Ō	ital or A	Çe				7				
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 1 ★ Certifying P (Check only one)	hysicien: To the best of miner: On the basis of and manner sta	examination and/or	becurred at the time time estigation, in my control	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
_	ro the vithin of the comple	Me	29b. Signature and tipe of certifier	- July Marinor Sta	1//	29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
	1) (<	1	A	03	7949	ľ	Dec. 315	72004
_										
	5		30. Name and address of person who	completed cause of de	eath (Nem 23a) (Type	e, Print)	1 1		1	21157
	5		Alexander Pro	To 1	X		ushe	ne, U	verente	72004 21157 n. MM2
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			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of latificate of		-	giene 0 0	4 41609
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	ACE	SCHEY	DT		2. Date of De Month DECEMP	Day	Year OS 45 A M
	Examir		4a. Facility Name (If not institution, give s HARBOR HOSPI 5. Social Security Number 6. Sex	FAL	(In the last birth do)	-	or Location of Deal	ARYLAN		TIMORE
	Funeral Director			M 2 ∑ F	(In yrs. last birthday) 78 Yrs.	Months Days			1926	9. Birthplace (State or Foreign Country) Maryland
	the Maryland 28a-f show	ector	10a. State 10b. County Maryland Anne Aru 10e. Street and Number	ndel	10c. City, Town or Lo				10g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with 23a or	ai Dir		cond Avenu	ıe		1225		USA	nat Country?
9036	parmit. Pages 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mental Ptygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show appring or other traumatic event, if a Medical Examinar must be neithed at Ances.	d by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0	Nas Decedent of f Yes, specify Cut I ☐ Yes 2⁄⁄ No	Hispanic Origin? (S pan, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
21215-0036	filad within 72 h Hygiene. other than "natu ant, Ir e Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	(Give	dent's Usual Occu kind of work done DO NOT use retire lerical	a during most of wa		Secreta Manager	arial ment
Maryland	2 should be filad within and Mental Hygiene. ia markad other than aumatic evant, It e Ma	To Be		Edward	Allen		Bertha	a Ameli		S
	1 and 2 sh Health and Iem 27 ia m		19a. Informant's Name/Relationship (Ty, Ellsworth Melvin Soloa. Method of Disposition			107 Seco	nd Ave			tate, Zip Code) L225 City or Town, State
Baltimore,	parmit. Pages Department of Important: If it any injury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Septice License		Bayview	Cremator	y 1/3,	/2005	Baltimo	re, Maryland
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused e cause on each line	the death. Do not ent	237 E Per the mode of dy	atapsco ing, such as cardia	Ave., Ba	Home, P	A. 21225-1856 Approximate Interval Between Onset and Death
	Physician /Medical Examiner	L	disease or condition resulting in death)	Due to (or as a	REBRA consequence of):	L HE	MORRI	IAGE		HOURS
8760,	sate be executed only sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):					
P.O. Box 68	The law requires that the death cartificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t	P ☐ Fetal death 3 ☐	Ectopic pregnand Other (specify)	ey .		23d. Date Mont	,
	w requires that been signed b should be deta		Part II. Other significant conditions cor	_	t not resulting in the u	, -				oute to the cause of death?
Division of Vital Records,	: The law icate has be page 2 sh	Completed by						24a. Was autor perfo 1 \(\text{Yes} \)	psy pri prmed? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vita	Physician: r this certificatal director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	it 2 ☐ ER/Outpatien	t 3 DOA Ot	hon	ath <i>(Check only c</i> Home 5 □ Resid	one) dence 6 □Other	(Specify)
ion of			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28c. Inju Wo			how injury occurred	
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor; After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry · At home, farm, str (Specify)	eet, factory, office		28f. Location (5 City or Tov	Street and Number wn, State)	or Rural Route Number,
	a Hosp 24 hou a Funei etely fil	Medicai	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	icien: To the best of er: On the basis of and manner stat	f my knowledge, death examination and/or inv ed.	occurred at the trestigation, in my	ime, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) and mand date and place, an	ner as stated. d due to the cause(s)
)	To th within To th	Me	29b. Signature and title of certifier Bunder	/ INT	ERN		se number 8722		29d. Date signed (
	10		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)	VER STR	REET, B		RE, MD 21225
	Sta Registi		31. Date filed (Month, Day, Year)		's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0058 4 December Grace Elizabeth Schruder 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Rockville Montgomery Shady Grove Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2√2 F Yrs. 005-24-6715 Director 76 10 / 30/ 1928 Maine Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ital Hygiene. ud other than "neturel", or items 23a or 28e-f show event, the Medical Espointer mat be notified at Hartford Connecticut Manchester 1 Yes Mo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 370 West Center Street 06040 United States Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Machinist Defense and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil iment of Health and Mental H tant: If item 27 is marked otf Wynfield Doody Annette McDougal traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Billings - Daughter 13321 Neurwinder, Place, Germantown, Maryland or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Bayview Crematory 01/03/05 Baltimore, Maryland * 4 ☐ Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate Kathleen Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tyndrome **Physician** Days /Medical or as a consequence of): **Examiner** Prelimania if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the as IF FEMALE: USB 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Dav Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 12 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signaturenand title of certifies 29c. License number

State

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 3 .2005

ALAN 5- CHANALLY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ROCKUILLE

State of Maryland / Department of Health and Mental Hygiene [] [] [] 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:14AM Roger Dale Shifflett **Physician**) t(/Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Howard Daniels 8027 Joetta Dr. Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Min. Months Days Hours **Funeral** M 2□F Maryland April 1, 1948 214-48-1903 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "netural", or iteme 23s or 28s-f ehow tre Medical Exarciner must be notified at 1 ☐ Yes 2 X No Elkridge Howard Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21075 8027 Joetta Dr. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amred Forces?

1 Yes 2 □ No 196
If Yes, Give 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 Married 1 Never Married 1967 1 ☐ Yes 2 No Specify: White altimore, Maryland 21215-0036 1969 3 Midowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) within 72 Transportation d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) School Bus Driver / Mechanic 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys McKenzie Raliegh David Shifflett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 st Department of Heelth and Important: If item 27 is n eny injury or other treun once. 8027 Joetta Dr. Elkridge, Maryland 21075 Wife Mrs. Mary R. Shifflett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 12/29/2004 **Bayview Crematory** 22. Name and Address of Facility 21. Signature of Funeral Sept Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardicuascular Disense Hherosclevotic **Physician** /Medical Due to (or as a consequence of): Examiner pirtensick Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injury that injury) Due to or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed typerchaleste that initiated events resulting in death) Last Box 68760. beter Physician/Medical the 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Duimonar Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No 2 No 1 ☐ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical exammer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatien1 2 ☐ ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 24 hours after death.

Funeral Director: After the etely filled in by the funeral 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and fittle of certifier Dec 27, 2014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellicot Cil MD 4565 Hernlockline Registrar's Signature Year) 31. Date filed (Month, Day, State Registrar

ORIGINAL

Physician /Medical Examiner 523 or 2884 show that be notified at Director 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ROBERT A. Facility Name (If not institution, g. 5 BETHWAY DRIVE) S. Social Security Number 074-38-4485 Usual Residence of Decedent 10b. County MD CARROLI 10c. Street and Number 5 BETHWAY DRIVE 11. Marital Status 1 Mover Married 2 Married 3 Widowed 4 Divorced	APT. # 103		SYKESVIL If Under 1 Year Months Days ocation	L E If Under 24 Hrs. Hours Min.	2. Date of Death Month DEC. 8. Date of Birth (Month, Day, 16/17/195)	Day Year 30 2004 4c. County of Do CARROL Year) 9. If	9:30P Birthplace (State or Foreig Country) N. Y.
Examiner Frontier at Director Director	As. Facility Name (If not institution, g. 5 BETHWAY DRIVE S. Social Security Number 074-38-4485 Usual Residence of Decedent 10a. State 10b. County MD CARROLI 10e. Street and Number 5 BETHWAY DRIVE 11. Marital Status 1 Never Married 2 Married	APT. # 103 Sex 10 M 2 F 7. Age APT. #103	(In yrs. last birthday) 49 Yrs. 10c. City, Town or Lo	4b. City, Town, o SYKESVIL If Under 1 Year Months Days	L E If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of Do CARROL Year) 9. 8	eath L Birthplace (State or Foreig Country) N.Y.
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3 5 F 2 6	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	DO NOT use retired	during most of worki	ing	16b. Kind of Busine	ss/industry
d other d othe	17. Father's Name (First, Middle, La	st)			18. Mother's Name	(First, Middle, N		
should be ind Ment in	EDWARD	(Time Drint)	SHE		GLORIA	10-11-5		ROSSMAN
nd 2 st lith and 27 ls n r traun	19a. Informant's Name/Relationship KENNETH SHEERS	/ BROTHER		LANCIA D	and Number or Rura	EAN, VA.		a, Zip Code)
permit. Pages 1 and 2 to Department of Health at Importent: If tiem 27 is any injury or other trau once.	20a. Method of Disposition 1 🗖 Burial 2 □ Cremation 3	· · · · · · · · · · · · · · · · · · ·	20b. Place of Dispo				20c. Location - City	or Town, State
permit. Pag Department Importent: I any injury o once.	'4 □ Donation 5 □ Other (Spe 21. Signature of Jungaral Service Lice	cify)		ION 2. Name and Addre	0 1/07	/2005	LYNDHURS	T, N.J.
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auth. or: After or: Atter he fune	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day		of 28c. Injur Wor	The second secon	28d. Describe how		Journal
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Hospi 4 hou 7 hou ely fill icai	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner sta	examination and/or in	th occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurre	and due to the car ed at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
To the within 2 romplet	29b. Signature and title of certifier	1000		29c. Licens	e number 5(924		od. Date signed (Mo	
11	30. Name and address of person w	o completed cause of de			0 0 0	Manch	1	11.2004

			1 - For State Registrar	State of Ma		artment of Hertificate of L		nd Mental Hyg	giene Reg. No. 2 ()	04	41613
H	°Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic Examin		Brett Randall 4a. Facility Name (If not institution, give			4b. City, Town or	Location of I	Death	4c. County	2009 of Death	1.01
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215	within 72 ene. then "ne	Completed	(Specify only highest gra	ade completed) College (1-4or 5+	life.	e kind of work done do DO NOT use retired)	uring most o Case	f working			
	lygien lygien her th		12	4	Class	sification	-	0			ernment
and	d be fill	Be c	17. Father's Name (First, Middle, Last) Richard Ott Schurt					Name (First, Middle, yn Hull	Maiden Surnan	ne)	
Maryland	should and Me mark umetic	ဥ	19a. Informant's Name/Relationship (7		19b. Mail	ing Address (Street a		or Rural Route Number	r, City or Town,	State, Zip	Code)
	and 2 ealth a n 27 is		Richard O. Schurm	ann Father				Catonsvil			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23s or 28a-f show any injury or other treumetic event, the Modical Examitrative trafficed at once.		20a. Method of Disposition Burial 2 Cremation 3		1 .	osition (Name of matory or other place	1		20c. Location -	City or Tov	wn, State
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Bret R. Schur MANN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** W 12250 Schmincke III December 30, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arbutus Baltimore 1256 Poplar Avenue 8. Date of Birth (Month, Day, Year) Apr. 26,] If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 XM 2 ☐ F 75 Yrs. Maryland 213-28-2881 Director Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1256 Poplar Avenue 21227 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 25 Married 1 ☐ Yes 2X No Specify: Specify: WHite 2 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7. h and Mental Hygiene. 7 is marked other then "n. College (1-4or 5+) Elementary/Secondary (0-12) Mechanic Stapling Machines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Schmincke Jr. Catherine Seibert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum <u>once.</u> Levern Schmincke Wife 1256 Poplar Avenue, Arbutus, MD 21227 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Baltimore National tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Cemetery 1-3-2005 Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Sycan /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 □ No 1 Yes 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospitel or Attending Pl 24 hours after death. e Funerel Director: After the Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel within 24 hours a To the Funerel I completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26256 12/30/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 WILKENS HE BALTIN BALTIMORE MO 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 03 Zuus Registrar

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		3 40	1. Decedent's Name (First,	<i>Aiddl</i> e, La	ist)						Date of Death	Day	Year	3. Time of Death
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<u>S</u>	death death ctor: y the	licat	3 ☐ Suicide 6 ☐ C	vestigation	e 29a Blace of Inc	urv - At home	. farm. stre		es ∠ _ IVC	-	ocation /Stre	et and Numbe	er or Rum	l Route Number,
<u>></u>	after after Dira	Certification:	4 Homicide	etermined	building, et	c. (Specify)	,,	o., radiory, 511100			City or Town,	State)	, o. , ia, a	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one)	tifying Ph lical Exar	nysician: To the best minar: On the basis o and manner sta	f examination	dge, death and/or inv	occurred at the timestigation, in my op	e, date and inion, death	place, and d	lue to the cau the time, date	se(s) and mar e and place, a	nner as st	ated. the cause(s)
	To the To the Comp	ž	29b. Signature and title of ce	rtifier				29c. License	number	-	290	d. Date signed	(Month,	Day, Year)
)	7		Johnsty	M.	9.			562	023	>	DE	CEMBER	28	3, 2004
	X		30. Name and address of pe						0	_				
	1 Page 1 1 1 1		31. Date filed (Month, Day,			ar's Signature		Avenue,	BALT	cimore	E MD	2122	7.	
	Sta Registr		JAN	0 3	2005	un a digitature		racks						

SMYTH, HARRIETTA.

		_	For State Ragistrar	State of Maryland		irtment of F tificate of			giene Reg. N2 0 0 4	41616
ı	Physici		Decedent's Name (First, Middle, Last) AUDREY		9	STEINBERG	à	2. Date of Dea Month DECEMBE	R 26, 200	3. Time of Death 7:52 A M
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of De	eath
	Funeral		SUBURBAN 1 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	ROCKVILL If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV . 10,		ONTGOMERY Birthplace (State or Foreign Country)
	Director		078-18-3539 Usual Residence of Decedent	M 2 X 79	Yrs.			NOV.10,	1925	NY
	anyland ahow	7	10a. State 10b. County MD MONT(GOMERY 10c. City,	, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	ith the Maryland or 28a-1 ahow	Director	10e. Street and Number	AUMERT	RUCKI	10f. Zip Code			10g. Citizen of What	
	s 23a o	erai D	1730 SUNRISE DRIV		2 42 1	Was Davidson of L	20854		14 Dags A	USA merican Indian,
9036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 ahow the Madical Examidian", ust be mailfed at	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ∭ No If Yes, Give Year or Dates:	1	∏Yes 2∭X No			Specify:	
1215-(within 72 h ene. than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		lent's Usual Occup kind of work done DO NOT use retired JNTANT	oation during most of worki d)		16b. Kind of Busines ACCOUNTIN	•
Maryland 21215-0036	should be filad withind Mental Hygiene. markad other than matic event, Ilie M	To Be Co	17. Father's Name (First, Middle, Last) JACK		BASSE		18. Mother's Name	(First, Middle,		LEVINE
	nd 2 shallth and 27 is m	2	19a. Informant's Name/Relationship (Ty CAROL MCQUEEN /	pe, Print) DAUGHTER	1	-			r, City or Town, State	
Baltimore,	0 0 = =		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 1 1 □ Donation 5 □ Other (Specify)	emoval from State		sition (Name of natory or other place HEBREW		31/2004	20c. Location - City REIST	or Town, State ERSTOWN, MD
Balti	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service License		22	. Name and Addre	ss of Facility SOL	LEVINS	ON & BROS	., INC.
	Physician		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition		. Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory ar		Approximate Interval Between Onset and Death 24 hours
Þ	/Medical Examiner	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) ence of):	hordae	tendin	nae		24 hours	
68760,	tificate be executad ig physician and as the burial-transif	edicai E	L.	1						
.O. Box	Attending Physician: The law requires that the death certificate be executed rideath. ector: Atter this certificate has been signed by the attending physician and better this certificate bas been signed by the tuneral director, page 2 should be detached for use as the burial-transif	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 Dr No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
rds, P.	w requires fhat been signed b should be deta	ed by Pl	Part II. Other significant conditions cor	ntributing to death but not resul	lting in the ur	nderlying cause giv	ren in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
Vital Records,	hysician: The law re his certificate has bee I director, page 2 sho	Complete			•			24a. Was a autop: perfor 1 Yes	sy prior t	
Vita	sician: certific lirector,	Be	25. Was case referred to medical examiner?	iospital:	ER/Outpatien	t 3 DOA Oth	26. Place of Death		ne) ence 6 ⊡Other (Si	and the
Division of	attending Phys death. ctor: After this y the funeral di	ation: To	27. Manner of Death 11 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injur Wor	y at		ow injury occurred	euny)
Divis	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre	eet, factory, office		281. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
	e Hospital or 24 hours afte e Funeral Dir letely filled in	dical	29a. Certifier 1 Certifying Phys. (Check only one) 2 Madical Exami	sician: To the best of my know nar: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and place, a pinion, death occurre	and due to the c ed at the time, c	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	r. Joanna h	V.Ku	29c. Licens	006150	16	29d. Date signed (Mo DECEMBE	nth, Day, Year) 1,26,2004
	30		30 Name and address of person who co	empleted cause of death (Item	23a) (Type, I	a 11	pital	Rock	(Ville N	n,26,2004
:	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 3 2	32. Registrar's Signati	ure					
DH	MH 17 Rev 1/2	001		,	1		·			

			1 - For State Registrar	State of Maryl		artment of H			iene _{eg. No.} 0 0	14	416	17
	Physici /Medi		Decedent's Name (First, Middle, Last, SAD I)	SALO	MON		2. Date of Dea Month DECEMBE	rh Day 8, 2	2ŎÖ'4	3. Time of 6:20	P M
1	Examir		4a. Facility Name (If not institution, give HOSPICE OF BALTIM	ORE GILCHRI			TOWSO	N		BALTI		
	Funeral Director		5. Social Security Number 6. Se 212-40-0801	X 7. Age (III)	yrs. last birthday) 98 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1906	9. Birthp Coun	lace (State o	or Foreign MD
	ne Maryland 8e-f show	ector	10a. State 10b. County N/A		:. City, Town or Lo BALT	IMORE					0d. Inside Cit	•
	e 23e or 2	Funeral Director	2500 W. BELVEDER			10f. Zip Code	21215		0g. Citizen of W		USA	
900	within 72 hours after death with the Maryland ene. than *naturel', or Itame 23e or 28e-f show f.s Madical Examiner must be natified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		was Decedent of hilf Yes, specify Cub 1 ☐ Yes 2 🔏 No		Specify Yes or No- rto Rican, etc.)		k, White,	an Indian, etc. WHITE	:
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygtene. item 27 is marked other than *naturel', or Itame 23s or 28e-f show tiem 27 is marked other than *naturel' critical Examiner must be neitified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire E MANAGE	during most of wo d)	orking	16b. Kind of Bu		•	
Maryland 2	2 should be filed within and Mental Hygiene. is marked other than eumetic event, It e Me	To Be C	17. Father's Name (First, Middle, Last) ABRAHAM		KUSE	LLE	18. Mother's Na	me (First, Middle, i	Maiden Sumam	•	MEYER	
	is 1 and 2 sho of Health and N item 27 is ma other treume		19a. Informant's Name/Relationship (7) JAY SALOMON / SC 20a. Method of Disposition	N		W. BELV		Ural Route Number		IMOR	E, MD	2121
Baltimore,	Page nent o ent: If ury or		1 M Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	cemetery, crea	natory or other pla HEBREW	CEM. 12/		BALT	IMOR	E, MD	
Ba	permit. Departi Import any Inj		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the	8	900 REIS	TERSTOWN	ROAD - P	IKESVIL			е
	/Medical physician and with a burial-transit the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause if Lot If defying Cause, (Disease or injury)	Due to (or as a cord). Due to (or as a cord). Due to (or as a cord).	nsequence of):	ongapa	try				Onset and D	Death
.O. Box 68	he death certifi the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	/		23d. Date Mon	e of delive		/ear
<u> </u>	w requires that the been signed by should be detact	þ	Part II. Other significant conditions con Renal Failure	ntributing to death but not	t resulting in the u	nderlying cause giv	ren in Part I.		pacco use contri	ibute to th	1.	eath? Jnknown
Il Records,		Completed						24a. Was a autops perform	y ned? d	Vere autor rior to con eath?	osy findings a npletion of ca	available ause of
ion of Vital	nding Phyeicien: Th ath. r: After this certificate e funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	28c. Injur Wor	er: 4 ☐ Nursing	ath (Check only on Home 5 \sum Reside 28d. Describe ho	ence 6 7 Othe		hespe	lie .
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, str pecify)	eet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	or Rurai	Route Numb	ber,
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	edical	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, deat mination and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occ	e, and due to the ca urred at the time, da	ause(s) and mar ate and place, a	ner as stand due to	ated. the cause(s)	
)	To t To t	Σ	29b. Signature and title of certifier Address of person who co	ompleted cause of death	(Item 23a) (Type.	29c. Licens D S		+ Baltu	ecens			f
	Sta	ite_	Ankon J. Cut- 31. Date filed (Month, Day, Year)	ARUS MO 32. Redistrar's S	(60)	N. Cho	rles s	+ Baltu	narem	15 0	204	
	Registi		JAN 0 3 2	005 Maria	1 15 1	mede						

SADIK SALOMON 12/28 @ 18:20

			_ For	State of Marylar	nd / Departm	ent of H	lealth and I	Mental Hy	giene	
			State Registrar		Certific	ate of l	Death	2. Date of De	Reg. No.	4 6 8
	Physici /Medic	al	Decedent's Name (First, Middle, Last) OUTIV 4a. Facility Name (If not institution, give s	treat and number)	Sci	hku City Town or	Md+ r Location of Death	Month Decem	Day ben 27 4c. County	
	Examin Funeral Director	er	5. Social Security Number 6. Sex 215-12-8541	olains Has	of al Bo	Afin nder 1 Year	one of If Under 24 Hrs. Hours Min.	8. Date of Bir	th ay, Year)	
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Location					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	r 28a-	irect	Md. Anne Ar 10e. Street and Number	undel N	Millersv 10f	111e . Zip Code			10g. Citizen of W	
	ath witi	ralD	1207 Dicus Mil			211				USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mantal Hygiene. Deperment of Health and Mantal Hygiene Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event, Ite Machinal Examinational Landled at Appea.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	 2. Was Decedent Ever in U Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 	If Yes,	ecedent of Hi specify Cuba is 21/2 No	ispanic Origin? (S) in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - American Indian, k, White, etc. : White
21215-0036	72 hou	eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's l	f work done d	during most of wor	king	16b. Kind of Bu	siness/Industry
121	within ene. than "	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NE	T use retired	()		Cmoran	, Cork & Seal
	al Hygid J other	Be C	17. Father's Name (First, Middle, Last)		Quaricy	COLLE	18. Mother's Nam	ne (First, Middle	, Maiden Sumam	e)
Maryland	should be nd Mental marked o	To	John H. Schlui 19a. Informant's Name/Relationship (Type		19h Mailing Add	roop (Stroot o	Joseph and Number or Ru		arpins	
	and 2 s salth an n 27 ls r		Margaret V. Sch							Le, Md21108
Baltimore,	Pages 1 an nent of Heal Int: If Item 2 Iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amoval nom State	Place of Disposition cemetery, crematory			Date	Anne A	City or Town State
IE III	ortant:	-	4 ☐ Donation 5 ☐ Other (Specify)21. Signature of Funeral Service License		oly Cross				Mary ki Eur	yland eral Home,PA
Ba	Depermine Depe		1 Robert freda		120	l Dun	dalk Av	enue B	altimo	re, Md 21222
	Physician		23a. Part1. Enter the lease, or complice shock, or heart flure. List only on Immediate Cause (Final disease or condition	eations that caused the deat e cause on each line.		1	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	Medical Examiner whysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	juence of):					
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rds, P	es pg es	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyi	ng cause give	en in Part I.			ibute to the cause of death? 3 ☐ Probably 4 ဤUnknown
Vital Records,	The ate h page	Completed							psy p prmed? d	Vere autopsy findings available rior to completion of cause of eath? Yes 2 \(\subseteq \) No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Dea			
of	0 S	ıtlon; To	1 Yes 278 No 27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 □ Nursing h		dence 6 Othe	
Division	in Diffe	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif		ctory, office		28f. Location (. City or To		er or Rural Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the tim tion, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)
	To t To tl	M	29b. Signature and title of certifier	2 1.1.		29c. License		00		(Month, Day, Year)
•	10		30. Name and address of person who cou	moleted cause of death (Iter	n 23a) (Type Print)	1	1/323	57	12	13012004
_	Ψ		Steven Schulm	an Md 6	00 Nonth	Wole	e St. E	Baltim	one, M	130/2004 any band 21287
	Sta Registr		31. Date filed (Month, Pay, Year) 201	32 Redistrar's Sidna	ature	الع			,	/

		4	For State Registrar	State of M	laryland		artmen rtificat			and M		Reg. No)	
	Physici /Medic	_	Decedent's Name (First, Middle, Last DIANNE TONEY)							2. Date of De Month DEC	ath Day	200	reer Kı	7:00 P M
	Examir		4a. Fecility Name (If not institution, give 4315 BREHMS LANE				BAU	TIMOR					NA NA		
Maria de la companya	Funeral Director		5. Social Security Number 6. Se 214-50-4666	x 7. A	ge (In yrs. las 54	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Dete of Bird (Month, De DEC 21,	y, Yeer)		Cour ARYI	
	ith the Maryland or 28a-f ehow	tor	10a. State 10b. County MARYLAND NA		10c. City,	Town or Lo	ocation							1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ith with the 23a or 28s	I Direc	10e. Street and Number 4315 BREHMS LANE				10f. Zip					10g. Cit	izen of Wh A	nat Cour	ntry?
036	er des items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No		Was Decedif Yes, spec			gin? (Spo n, Puerto	ecify Yes or No Rican, etc.)	-	Specify:	Amend White, AFRIC	etc. CAN
21215-0036	hin 72 hours eft e. an "naturel", or Medical Exerci	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed) College (1-4or		16a. Deced (Give life.	dent's Usua kind of wo DO NOT us	rk done a	lurina mosi	t of work	ing		ind of Busi		dustry ADMINISTRATIO
Maryland 21	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be Corr	12 17. Father's Name (First, Middle, Last) ALBERT KNIGHT SR.	NA		ADMIN	ISTRAT	IVE SI	18. Mothe		e (First, Middle,				MATHEMATIC
Mary	nd 2 shoulth and N		19a. Informant's Name/Relationship (T ERNEST LEE TONEY	ype, Print) HUSBAND			ng Address BREHM				al Route Numbe IMORE, MA				Code)
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		cer	ce of Disponetery, crer	matory or o	ther place	J	AN 3,		Bal	cation - C	ore	Mary Cana
Balt	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service Licens	molas		6	38 N. (GILMOR	RSTRE	ET B	LIE FUNER ALTIMORE,	MAR		-	
	Physician /Medical Examiner		Part1. Enter the dise se, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	LUN		ANC	EE E	e or dying	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death MONTHS
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ds, P	S 6 0		Part II. Other significant conditions co	ntributing to death	but not result	ling in the u	nderlying o	ause give	en in Part I.			obacco (Yes 2		DP ob	ne cause of death? ably 4 DUnknown
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f Vital	certific rector	To Be	25. Was case referred to medical examiner? 1 Yes 2 THO	Hospital: 1 ☐ Inpat	tient 2 E	R/Outpatier	nt 3 🗆 DC	Othe	ar.	7-5	me 5 □ Desi		t 6 □Other	(Specify	y)
sion of	Jing After fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In		28b. Time o Injury	f 2	8c. Injury Work 1 🔲	rat k? Yes 2□	No	28d. Describe l				
Division	To the Hospitel or Attenk within 24 hours after death To the Funerel Director: completely lilled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	200. Place Ul II	niury - At hometc, (Specify)	he, farm, str	reet, factor	, office			28f. Location (. City or To			or Rura	il Route Number,
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	vithin 2 To the Complet	M	29b. Signature and title of certifier	Buelie	MAD				P Y Z	52					Dey, Year)
	1.0		30. Name and address of person who of	: ND 76	00 05	LER 1	Print)	E 70	ows	ON,	MARYL	ANO	21	20	4
	Sta	ite	31. Date filed (Month, Day, Year)	2005 32. Regis	trar's Signatu	ire 	1				-				

DHMH 17 Rev 1/2001

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			1 - For State Registrar	State of I	Marylar	nd / Depa	artmen	t of H e of L	lealth a	and M	lental Hy	/gienez Reg. No.	004	41	620
	Physici /Medic		Decedent's Name (First, Middle, Jam	Last) es L. Thom	npson						2. Date of Domestin Month Decemb	Day	Year 2004	3. Time	of Death O P ^M
	Examin		4a. Facility Name (If not institution,		er)		,		Location				ounty of Deat	th	
			Suburban Hospi		A (1	for a bringh of a st	If Under		esda If Under	Od Hee			lontgo		
1	Funeral Director		217-28-7802	5. Sex 7. 1⊠M 2□F	74	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D March 1.	nth ay, Ye <i>ar)</i> 5 , 193	0 In	hpiace (Stat buntry) .diana	e or Foreign
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside	City Limits
	Marylis f sho	Ď	Maryland Montgo	merv		•	Rockv	ille							es 2 No
	r 28a-	rect	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?	
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36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "neturel", or Items 23a or 28a-f show injury or other treumetic event, If a M-dic-I Exacility at institut at injury or other treumetic event, If a M-dic-I Exacility or other treumetic event, II a M-dic-I Exacility or other treumetic event.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force d 1 \(\text{Yes} \) 2 { If Yes, Give Year or Date	ss? □No		Was Deced If Yes, spec 1 ☐ Yes 2				ecify Yes or N Rican, etc.)		. Race - Ame Black, Whit pecify:		
200	72 hou	ted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usua	I Occupa	ation	et of work	na	16b. Kind	of Business/	Industry	
21	ithin 7 ne.	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of wor DO NOT us					77 1	1 0		
2	iled w tygier ther ti		17. Father's Name (First, Middle, La	4		Forei	gn sei	LATC			(First, Middle		al Gov	vernme	nt
Maryland 21215-0036	wild be f Mental H arked of	To Be	Louis Francis	•							e Elle:		,		
Mar	od 2 sho lth and 27 Is ma		19a. Informant's Name/Relationshi Rozelle Thompson								ille,				
altimore,	ges 1 ar t of Hea If item 5 or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3		ite (Place of Dispo cemetery, crei	sition (Nam natory or ot	ne of ther place	e) J		ry 1,	20c. Local	tion - City or	Town, State	
III.	rtmen rtmnt: rtant: njury		' 4 □ Donation 5 □ Other (Spe		Mon	ntgomery				200.	5	Bethe	sda, M		
Bal	permit. Pages 1 Department of H Important: If ite any injury or otl once.		21. Signature of Funeral Service Li	censee	M00	198 R	obert 57 Wis	A. cons	Pumph Sin Av	rey re., I	Funera Bethesd	1 Home a, MD	Bethe Chas 20814-	esda-C Se In 350I	hevy c.
			23a. Part1. Enfor the disease, or c shock, or heart failure. List of	omplications that caus nly one cause on eacl	sed the deat h line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory a	ırrest,		Approxim Interval 8 Onset an	etween
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a		Rectum								4 mon	
	Examiner		resulting in death)	Due to (or	as a consec	quence of):									
E.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (classes of injury)	b. — Due to (or	as a conseq	quence of):									
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90,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or	as a conseq	quence of):									
8760,	cate b physic the b	dlca		d											
O. Box 6	death certif e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	1 2 ☐ Feta t at time of d	al death 3	Ectopic pre Other (spe	egnancy ecify)				230	I. Date of deli Month	very Day	Year
<u>α</u>	res that igned by be deta	by	Part II. Other significant condition Cancer of Pros		h but not res	sulting in the u	nderlying ca	ause give	n in Part I.			-	contribute to		
oro	w require been si should b	eted											lo 3∏Pro		
of Vital Records,	The lar ate has page 2	Completed	Coronary Arter	y Disease							24a. Was auto perfo		th. Were au prior to death? 1 ☐ Yes	topsy finding completion of 2 \(\square\) No	s available cause of
Vita	icien: Th	Be	25. Was case referred to medical examiner?	Hospital:				Otho	-		(Check only				
of	Physicien: r this certific ral director,	- To	1X Yes 2 No 27. Manner of Death	1 □ Inpa	_	ER/Outpatien 28b. Time of		A Othe Bc. Injury	4 140		ne 5 Resi 28d. Describe			eify)	
on	Attending Frideath. sctor: After by the funer	tlon	1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, I	Day Year)	Injury	м	Work	:?` ∕es 2 ⊡ l		.bu. Describe	now injury o	ccurred		
Division	l or Attendatter death Director: In by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At he etc. (Specif	ome, farm, str fy)	eet, factory,	, office		- 1	28f. Location (City or To	Street and N wn, State)	lumber or Ru	ral Route Nu	ımber,
_	To the Hospitel or At within 24 hours after of To the Funerel Direc completely filled in by		29a. Certifier1 \(\text{X Certifying} \)	Physician: To the be	st of my kno	owledge, death	occurred a	at the tim	e. date an	d place, a	and due to the	cause(s) and	d manner as	stated.	
	n 24 h	edical	(Check only 2 Medical Ex	xaminer: On the basis and manner	s of examina	ation and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time,	date and pla	ace, and due	to the cause	o(s)
	To the Vithin 2 To the complet	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Date s	igned (Month	, Day, Year)	
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1	1211		30. Na ddress of person w Ravi Passi, M.I	ho completed cause o	-			B. S	ilve	r Sni	ino. M	arv1 or	nd 200	10	
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	Registr	ar	JAN 0 3 20	UN STREET	1 55	1									

State of Maryland / Department of Health and Mental Hygiene 004 4 621 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** William Raymond Thiele 2004 1749 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7308 Forest Ave Hanover Howard If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months t<u>√</u>M 2□ F 219-30-1046 70 Yrs Director Maryland 8-8-1934 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov other traumatic event. The Medical Examiner must be nutilled at MD Howard Hanover 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ŏ Iteme 23a 7308 Forest Ave 21076 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ A If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 □ Divorced "neturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Importent: if item 27 is marked other that any injury or other traumatic event. ITEL Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William August Thiele Dorothy May Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Thiele, daughter Elkridge, MD. 8021 Joetta Dr. 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Most Holy Redeemer 12-28-04 Baltimore, ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. epoura C 1328 Sulphur Spring Rd. 21227 Arbutus, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician hronic COUR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ear Due to (or as a consequence of) Examine certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 **M** No 1 ☐ Yes Hospitel or Attending Physician: 24 hours after death Funerel Director: Atter this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 5 Hesidence 6 □Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) Dec 24, 2004 ME 30. Name and address if person who combleted cause of death (Item 23a) (Type, Print) Way Ellrott City MV 21042 PATRYCE 4565 TOYE, MY emlock (31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 3 2005

	1 46		1 - State of Maryland / Department of Health and I Certificate of Death		giene 004	41622
	Physici /Medic Examin	al	icarae 1	2. Date of Dea Month	Day Year DR 7 30 2004 4c. County of Deat	3. Time of Death O \ 2 \ A M
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 82 Yrs. 6. Sex 1 Nonths 1 Under 1 Year 1 Under 24 Hrs. Months And	8. Date of Birth (Month, Day OCT 2	y, Year) Co	nplace (State or Foreign untry) ERU
	e Maryland 3a-f ehow tillied at	ctor	10a State 10b. County 10c. City, Town or Location MD. N/A BALTIMORE			10d. Inside City Limits XYes 2 □ No
	ath with the 23a or 21	Funeral Director	10e. Street and Number 502 S. PATTERSON PARK AVENUE 21231		U.S.A.	
9600	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow iteal Examinat must be notified at	by	If Yes, Give 1 Ma Yes 2 No Specify: PET	pecify Yes or No- o Rican, etc.)	Specify: WH	o, etc. ITE
121215-0036	filed within 72 Hygiene. sther than "nat sont, the Madica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 + STRUCTURAL ENGINEER This is a Do Not use retired STRUCTURAL ENGINEER	?	NATIONAL AGENC	SECURITY
Maryland	should be find Mental H marked of umatic ever	To Be	TIOFILO VILLAGARAY SIXTA	POMA	Maiden Sumame)	
altimore, Maı	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ehow any figury or other traumatic event, it a Marked Examinat must be notilised at DDCs.		1 VBurial 2 Cremation 3 Removal from State	ARK AVE	BALTIMO 20c. Location - City or 1	RE, MD.
Baltin	permit. P Departme Important any injury		3 SACRED HEART OF JESUS 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility LILLY & ZEILER I 1901 EASTERN AVE	NC. FU	NERAL HOM	E
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a			Approximate Interval Between Onset and Death Minutes
8760,	eate be executed shysician and the burial-transit	sal Examiner		Bleed		hours
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delice	very Day Year
	The law requires that the site has been signed by the bage 2 should be detache	by	Parti, build significant conditions contributing to death but not resulting in the underlying cause given in Parti.		bacco use contribute lo es 2 XNo 3 ☐ Pro	the cause of death?
Vital Records,		Completed			med? prior to co death? 2 No 1 Yes	opsy findings available ompletion of cause of
Division of Vit	tending Ph leath. tor: After th the funeral	Certification; To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Hospital:	28d. Describe ho	ence 6 Other (Speci ow injury occurred	
Ω	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical Cer		and due to the c	ause(s) and manner as slate and place, and due t	stated.
	To the within 2. To the complete	Med	29b. Signature and title of coefficier 29c. License number	2	9d. Date signed (Month,	Day, Year)
7	b		30. Name and address, 1 person who completed cause of death (Item 23a) (Type, Print)	6	12/30/04	(
	Sta Registr	_	30. Name and address person who completed cause of death (Item 23a) (Type, Print) Michael Louble Louble of Bound of Month, Day, Year) JAN 0 3 2005	21287		

			For State Registrar	State of Mary			Health and Me Death	•	2006	41623
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Las A. Facility Name (If not institution, give	William J.	Washir			Date of Death Month	Day Year	3. Time of Death
	Funeral Director		5. Social Security Number 6. Security Number 213-58-4050		yrs. last birthd.	Months Davs	r If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry) Md
2	ith the Maryland or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md	N/A 100	: City, Town or Balto	Location				10d. Inside City Limits
9	leath with the ns 23a or 28 hiust be no	Funeral Director	10e. Street and Number 11 Walnut Avenue 11. Marital Status	12. Was Decedent Ever	in U.S. 1		21206		Citizen of What Co U S A	
/ i /	72 hours after death with the Maryland 72 hours of tems 23e or 28e-f show Acel Examitment just be motified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		If Yes, specify Cut			Black, Whit	te, etc. Black
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1 Sport	es 1 and of Heall		William E. Washi 20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify	Removal from State		1 Cedar of sposition (Name of prematory or other placemorial Page 1997)	1-4-20	20c	Md 21239 Location - City or Candalls to	
7 2 2	permit. Pag Department Important: I any injury o	la l	21. Signature Funeral Service Licens	C. Skugs	ut	22. Name and Address 430	ess of Facility Mar O Wabash Ave		West to, Md 2	
	Physician /Medical Examiner	Examiner	20a. Part1. Enter the disease, or compshock, or heart failure. List only compensate the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of High that initiated events resulting in death) Last	a. PE Due to (or as a cor CHF Due to (or as a cor	sequence of):	one the made of gy	ng, such as cardiac of re	sspiratory an est,		Approximate Interval Between Onset and Death 1/2 Hours
© Box 68760	eath certificate attending phys	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a cond. 23c. If yes, outcome of present the conditions of the conditi	egnancy Fetal death	3 ⊟Ectopic pregnanc 5	ey		23d. Date of deli	ivery Day Year
rds P.O.	w requires that the d	by	9 ☐ Unknown Part II. Other significant conditions co		resulting in the	underlying cause gr	ven in Part I.		1	the cause of death?
Beco	n: The law required has been by, page 2 should	Completed	25. Was case referred to medical			-		24a. Was an autopsy performed 1 Yes 2	prior to death?	itopsy findings available completion of eause of 2 □ No
Division of Vital Records	Itanding Physician: death.	Certification; To Be	eyaminer?	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea		of 28c. Inju	Yes 2 □ No	5 Residence . Describe how in	njury occurred	
Öivi	To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fi		4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - / building, etc. (Sp sician: To the best of my	knowledge, de	ath occurred at the fi	me date and place, and	due to the cause	e(s) and manner as	stated
	To the Ho within 24 to the Fu completely	Medical	(Check only one) 2 Medical Exam	ner: On the basis of exam and manner stated.	nination and/or	investigation, in my o	opinion, death occurred a	at the time, date a	Date signed (Month	to the cause(s)
	5		30. Name and address of person who c	ompleted cause of death	(Item 23a) (Typ	o Brint)	05985		729	12004
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3	32. Registrar's S	ignature	Soule	VIIVEDO-I	IMOI	-,1118	4-143/

04-084 **AARON** WHM

Baltimore, Maryland 21215-0036

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/Medio		4a. Facility Name (If			n <i>ber)</i>			4b. City, Town,	or Location of		ECENDE		County of Deat	12:16 P M
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Funeral Director		5. Social Security Nu 219-48-98	377	ex [3_M 2□F	7. Age (In yrs 60		hday) (rs.	If Under 1 Year Months Days		Min. Fe	Date of Birth (Month, Day, eb 24,	Year) 1944	9. Birt Co Wasl	hplace (State or Foreign unitry) hington DC
and		Usual Residence of 10a. State	Decedent 10b. County		10c. C	ity, Town	or Lo	cation						10d. Inside City Limits
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tems	Funerai	11. Marital Status		12. Was Dece Armed Fo	rces?	U.S.	13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin can, Mexican, F	n? (Specify Puerto Ric	y Yes or No-		14. Race - Ame Black, White	nican Indian,
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atura cul E			15. Decedent's Ed	lucation		16a.	Deced	lent's Usual Occu	pation			16b. Kir	nd of Business/	Industry
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s 1 ar f Hea item other		20a. Method of Dispe	osition			Place of	Dispos	sition (Name of natory or other pla	ace)	Date			cation - City or	
Page nent o int: If]Cremation 3 □ 5 □ Other <i>(Specif</i>)		116	trop	oli	tan	1.	/5/20	05 A	1ex	andria	Va
permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Meulcal Exercitor must be notified at once.		2 Sign turn of Fun	neral Service Licen	see A		emat	7	Name and Addr Iexander	ess of Facility	ne Fu	neral	Нот	0	
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law requires that the as been signed by th 2 should be detache	by Pr	Part II. Dther signific	cant conditions co	ontributing to de	eath but not re	sulting in	the un	derlying cause gr	ven in Part I.		23e. Did tob	acco u	se contribute to	the cause of death?
quires nn sign uld be	q pe	Hypot	hermia								1 □ Y€	s 2 7	(No 3□ Pr	obably 4 Unknown
aw re	piet	Renal	disease	eh h	remodi	alive	53				24a. Was a		24b. Were au	topsy findings available
The I	Completed	Diab	etex Ma	illitus		0					autops perform	ned?	death?	completion of cause of 2 No
ertifica ector, 1	Be	25. Was case referre	ed to medical							of Death (C	heck only on			
rhis certific ral director,	P	¥XYes 2□N	10			ER/Out		3 DOX		7	5 Reside		Other (Spec	city) SCENE
After funer	ion:	27. Manner of Death 1 ☐ Natural	5 Pending		h, Day Year)		ijury ,		iry at ork?]Yes 2 X ∫No	Su	Describe ho	ed tr	rcin arter	icipuous shunt
death death ctor: y the	ficat	2 X Accident 3 Suicide	investigation	28e. Place	2 29 04 of Injury - At I	nome, far		et, factory, office			Location /St	reet and	ad the co	ral Boute Number
the Hospital of Attending hin 24 hours after death. the Funeral Director: After hipletely filled in by the fune	Certification:	4 🗌 Homicide	determined	buildi	ng, etc. (Spec	ify) ,	hon			Sa	City or Town	, State)	i3013 c	id forte Rd
hours unera ly fille	sai C	29a. Certifier (Check only	1 Cartifying Ph	ysician: To the	best of my kn	owledge.	death	occurred at the t	ime, date and p	place, and	due to the ca	use(s)	and manner as	stated.
to the Hospital of Attending Phyaician: The law requires that the death certilicate be thin 24 hours after death. Ithin 24 hours after deather the this certificate has been signed by the attending physicial ompletely filled in by the funeral director, page 2 should be detached for use as the burnarial director.	Medicai	onej	2 Madical Exam	and mani	ner stated.	alion and	JUI INV			occurred a				
0 = 0 5		29b. Signature and t	INTER OF COLUMBI					LZGC. LICON	se number		2	ou. ∪ate	e signed (Month	, way, rear/

Division of Vital Records, P.O. Box 68760, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu

29b. Signature and title of certifier

29c. License number OCME 29d. Date signed (Month, Day, Year) DECEMBER 30, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D LINGLI

State Registrar

31. Date filed (Manth, Day, Year)

JAN 0 3 2005 trar's Signature 111 PENN STREET, BALTIMORE, MARYLAND, 21201

			For State Registrar	State of Maryland	l / Depa		t of H	ealth a		ental Hyg		2001	4162
is L	Physici /Medio		1. Decedent's Name (First, Middle, Last) Robert Duane	e Wallace Sr.						2. Date of Dea Month Dec.	th Day	Year 2004	3. Time of Death 7:55A ^M
)	Examir		4a. Facility Name (If not institution, give s 9108 Town & Countr 5. Social Security Number 6. Sex	cy Blvd. Apt.D			E11i	Location o CO tt If Under 2	City	8. Date of Birth		County of Death Howa 9. Birth	rd
	Funeral Director		216-28-0203 Usual Residence of Decedent	M 2□F 76			Days	Hours	Min.	(Month, Day March	, Year)	1928 N	place (State or Foreign ntry) Minnesota
	the Marylar 28a-f show	Director	Maryland Howard 10e. Street and Number		Town or Lo						Ing Citi	zen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
936	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23e or 28e-f show marked other then "natural", or litems 25e or 28e-f show imatic event, it a Medical Examine mast be notified at	by Funerai	9108 Town & Count	ery Blvd. Apt 2. Was Decedent Ever in U.S Armed Forces? 1 Yes. Give Year or Dates:	. 13. V		210 ent of Hi rfy Cubar		gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	Ur	nited St. 14. Race - Ameri Black, White, Specify: Wh:	ates can Indian, etc.
Maryland 21215-0036	d within 72 horgiene. In them "nature. If a Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation completed) College (1-4or 5+) 2 years	16a. Deced (Give life. L	lent's Usua kind of wor DO NOT use Chanic		ition u <i>ring m</i> ost	of workin	ng .		nd of Business/Ir	,
yland	should be filed and Mental Hygie marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Ralph Emmerso						I	(First, Middle, Eva Faye	e Al	len	
	s 1 and 2.		19a. Informant's Name/Relationship (Type Barbara Ann Wallac 20a. Method of Disposition 1 □ Burial 2 ØCremation 3 □ Re	ee Wife	910 ce of Disponetery, cren	08 Townsition (Name	n & le of her place	Coun	try I	Blvd. A	20c. Lo	Ellicot cation - City or To	
Baltimore,	permit. Page Department o Important: If eny injury or		*4 □ Donation 5 □ Other (Specify) 21. Synature of Funeral Service License	ALL	Bu	. Name and	Addres	s of Facility	unera	31, 2004 al Home Road S	& C	ykesvili rematory	
/60,	Priysician /Medical Examiner	cal Examiner	a. P. 11. Enter the disease, or complic lock, or heart failure. List only on the sease of condition resulting in death) Sequentially list conditions, laws (Disease or injury that inflated events resulting in death) b. Cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a conseque	Do not enter	er the mode	of dying	, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death MCNTHS
P.O. Box 687	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	an/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pre					2	23d. Date of delive Month	ery Day Year
	w requires that to be the signed by should be detailed.	ed by Physici	Part II. Other significant conditions cont		•	nderlying ca	use give	n in Part I.		23e. Did tot			he cause of death?
Vital Records,		Completed	LENONIARY ART	, /						24a. Was a autops perform 1 Yes 2	y ned?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of
Division of Vita	To the Hospital or Attending Physician: within 24 hours after deals or 17 the Funaral Director: Attenthis certific completely filled in by the funeral director.	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatient 8b. Time of Injury		lc, Injury Work	r: 4 □ Nur at	sing Hom	Check on on e 5 ☑ Reside 8d. Describe ho	ence 6	☐Other (Specify coccurred	y)
DIVIS	e Hospital or Attu n 24 hours after de le Funeral Directo letely filled in by to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)					;	City or Towr	n, State)		
	To the Hosp within 24 hou To the Funel completely fil	Medical	29a. Certifier (Check only one) 1™ Certifying Physic 2 Medical Examin one) 29b. Signature and title of certifier	ician: To the best of my knowler: On the basis of examination and manner stated.	n and/or inv	estigation,	in my opi License	number	occurre	d at the time, da	ate and 9d. Date	place, and due to signed (Month,	Day, Year)
2	1		30. Name and address of person who con	impleted cause of death (Item 2) STERRIS MI	(Type, I			5613 Ali De	_	TE. 2018		130/20 WIT CHTY 1	/
	Sta Registr		30. Name and address of person who con JENNIFER SHAW 31. Date filed (Month, Day, Year) JAN 0 3	32. Registrar's Signatur	re de	facili	2	90					1 -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month KOETER let WILLIAMS 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RICHEY RHUD JOSEDH Date of Birth (Month, Day, Year) 516167 5. Social Security Number Sex 1XIM 2□F 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 212-38-3160 Usual Residence of Decedent Yrs Director 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28e-f show traumatic event, the Mudical Exercines must be notified at 1 Yes 2 □ No Director MD BALTO CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death w Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or Items 23a cany lightly or other traumatic event, tra Mudical Experiments 20a cany. USA AVE 71218 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: BUACK Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCHILE MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JIMMY WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HANTRESS WILLIAMS, MOTHER BALTO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 □ Cremation 3 □ Removal from State
4 □ Dogration 5 □ Other (Specify) GARDENS OF FAITH! BAUD, MD 21213 1/04/05 of uneral ervice I 21. Sign fur 22. Name and Address of Facility MILLERS METRO POLITAN CHARES N BRUADWAY BALD MD 21213 23a. Part1. Enter the disea shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9☐Unknown 9 Unknown by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe rmed? 2 V No 1 🗌 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: 4 Nursing Home 5 Residence Certification: To After this of 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manuar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) λq 4 Homicide hours after within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

e 31. Date filed (Month, Day, Year)

PAVID

Win

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For State of Maryland / Do	epartment of Health and M Certificate of Death	ental Hygier		1627
	Dhuoisi		Decedent's Name (First, Middle, Last)		2, Date of Death	3.	Time of Death
	Physici /Medio		Foster J. Woods				L:52 P M
	Examin	ier	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
	Funeral Director		5. Social Security Number 6. Sex 1 № 4 2 F 89 Yr	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 12,	9. Birthplace Country) Uta	(State or Foreign ah
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or 10	or Location		10d. li	nside City Limits
	a-1 eh	tor	Maryland Montgomery Silver	Spring		1	☐Yes 2X No
	h with the	ai Direc	10e. Street and Number 9623 Flower Avenue	10f. Zip Code 20901		Citizen of What Country?	3
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ehow amy injury or other traumatic event, the Medical Eracificat must be notified at page.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ NoWorld If Yes, Give Year or Dates: Married Year or Dates: Married	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto It 1 ☐ Yes 2 ☒ No Specify:	cify Yes or No- Rican, etc.)	14. Race - American In Black, White, etc. Specify:	
9	2 hour	ted b	15. Decedent's Education 16a, D	ecedent's Usual Occupation	16b.	White Kind of Business/Industr	
21215-0036	thin 72 9. an "ng	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of workir ife. DO NOT use retired)	207	deral	,
2	led wi tygien har th	Cou	12 – Fuel	l Technologist		vernment	
anc	id be fi ental h ked ot c eval	To Be	Joseph Taylor Woods		(First, Middle, Maid ice Woods	en Surname)	
Maryland	and Marl	1-		Mailing Address (Street and Number or Rura			,
	and 2 lealth m 27 I			30 New Hampshire Aver			
altimore,	ages 1 nt of H t: if ita / or ot		1X Burial 2 □ Cremation 3 □ Removal from State Pai	cjematory or other place) Janua:	ry 3, _	Location - City or Town, S	
Ħ	nit. Parantmen ortant injury		'4 □Donation 5 □Other (Specify) Memoria 21. Signature of Funeral Service Licensee	al Park 2003	ert A. Pur	kville, Mar mphrey Funer	al Home/
č	Dep imp any		M00689	Rockville, Inc. 300 Rockville, Maryland	West Mona d 20850-28	tgomery Aven 305	iue,
			23a Part I inter the disease, or complications that caused the death. Do no shock or learnfailure. List only one cause on each line (App	roximate rval Between set and Death
	Physician /Medical	i i	Immediate Cadse (Final disease or condition resulting in death)	Calmia,	PRODU	Olis	et and Death
	Examiner		Due to (or as a consequence of	especation h	M000 m	Min	
	p is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	is person in	roccorno	, cc×	
_	xecute and Il-trans	Examin	Cause (Useass or injury that initiated events c	:			
38760,	ficate be executed physician and is the burial-transit	dicai E	d				
v	ntificat ng phy s as th	w w	IF FEMALE:				
Вох	seath certifi attending I I for use as	Physician/M	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of delivery Month Day	Year
o	res that the de signed by the a be detached f	hysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)			
S, D	gned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco	use contribute to the cau	use of death?
ord	w require been si	eted	alla fimilale	<u>// (F)</u>	1 🗆 Yes	2 No 3 Probably	4 Unknown
Il Records,	The lar	Completed	V		24a. Was an autopsy performed?		ion of cause of
Vita Vita	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	26. Place of Death Other: 4 Daysing Hor			
0	ding Phys h. After this funeral di	n: To	1 ☐ Yes 2 ☐ No Hospital: ☐ Inpatient 2 ☐ ER/Outp 27. Mannar of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at 2	ne 5∐ Residence 8d. Describe how inj	6 ☐Other (Specify) jury occurred	
sion	anding sath. or: Aft he fun	atio	1 Natural 5 ☐ Pending (Month, Day Year) Inju	M 1 ☐ Yes 2 ☐ No			
Division of Vital	al or Attans s after deat al Director: ad in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	a, street, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Rou ite)	ite Number,
	To the Hospital or Attanding Physician: within 24 hours after deals. Within 24 hours after deals. Within 25 hours after deals.	Medicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, a or investigation, in my opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as stated. nd place, and due to the o	cause(s)
	To tha	×	29b. Signature and the of certifier	29c. License number	29d. D	Pate signed (Month, Day,	Year)
	/\		20 Name and address of appropriate completed arrays of death (it was 20 V 7	5614		12/28/	09
	01,		30. Name and address of person who completed cause of death (Item 23a) (Ty DR. N. KANGO 7610 CARIO	2011 AVE. TAKAN	1A PAR	k Md 2	1912
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2005 33 Registrar's Signature	COLL AVE. TAKOM			
ш			And Million and Indian				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylan			of Health a of Death	na wen		g. No.	+ 41628
	Physicia	an	1. Decedent's Name (First, Middle, Last		: 10			1	Date of Death Month	_Day Yea	
	/Medic	al -	WILLIAM HOM 4a. Facility Name (If not institution, give		2 1/1/6	4b. City, To	own, or Location of	-	ec	4c. County of D	<u> </u>
	Examin	er	CARROLL HOSPITI				TMINST			CARR	
	Funeral Director		5. Social Security Number 6. Se 217 18 3888 1	7. Age (In yrs. 79)	last birthday) Yrs.	If Under 1 Months	Year If Under 2 Days Hours	Min. /	Date of Birth Month, Day, UG 16	Year)	Sirthplace (State or Foreign Country) MARYLAND
	ryland how		Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo		TE0				10d. Inside City Limits 1 ☐ Yes 2 No
	ith the Marylan or 28a-f show	ecto	MO CARA	.022 6	NE51	10f. Zip C			10	g. Citizen of What	
	3a or 2	Funeral Director		TER ROAD			21158			USA	
	ems 2	unera	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decede If Yes, specif	nt of Hispanic Orig y Cuban, Mexican,	in? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
200	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "natural", or items 23s or 28s-f show avent. The Medical Examinal must be notified at	ρ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 No 19 If Yes, Give Year or Dates: 9	9	1 ☐ Yes 2	No Specify:			Specify:	white
5	72 ho	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual kind of work DO NOT use	done during most	of working	1	6b. Kind of Busine	ss/Industry M STEEL
7	within ene. than	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ERVIS	-			SHIPBUIL	
ב פ	e filed al Hygi other vent.	BeC	17. Father's Name (First, Middle, Last)		<u> </u>		_			laiden Sumame)	,
ylar	ould b Ments varked vatic e	To	William Homer		SR 10h Mail	ing Address /				City or Town, State	
Mar	td 2 sh Ith and 27 is n treum		19a. Informant's Name/Relationship (1) E017H H. WINTER		333		TER PO			hINSTER !	
ce,	ss 1 an of Heal litem 2 r other		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. F	amotoni oro	osition (Name	e of	Date		Oc. Location - City	
baltimo	. Page tment tent: It		4 □Donation 5 □ Other (Specify		en Gree	NEW	M. GAR. 1	13/20	05 F	-INKSBU	26, MN
na	permit. Pa Departmer Importent any injury once.			mbrun	ϵ	028	SYKESVIL	LE RO	ELO		MO 21704
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	uence on:	001	0- En	who	em	4	lyeun
	Examiner		Sequentially list conditions	. Preum	emo	2					July
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						
,	execution and rial-train	Exar	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
9/8 8	ficate be executed physician and s the burial-transit	edicai		d							
9			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn	ancy					23d. Date of	
O. Box	0 0 0	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown		□Ectopic pre □ Other (spe				Month	Day Year
ב	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions of				use given in Part I.				e to the cause of death?
ord	w require been sig should b	ted !	Bulateire 1.	ewaltEffu	Som	3			1 🗆 Ye		Probably 4 Unknown
Vital Records,	e las has je 2	Completed							24a. Was ar autops perform 1 Yes 2	prior deat	autopsy findings available to completion of cause of 1? Yes 2 No
ital		Be Co	25. Was case referred to medical examiner?					of Death (C	heck only on		
	hysic this ce al direc	2	1 Yes 2 No		28b. Time					nce 6 Other (5	Specify)
ono	th. After funer	tion	11 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day Year)	Injury	м	3c. Injury at Work? 1 ☐ Yes 2 ☐ I			. ,	
Division of	or Atter after dea Director	Certification:	3 Suicide 6 Could not be determined		nome, farm, s	treet, factory,	office	28f.	Location (St. City or Town	reet and Number o , State)	r Rural Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier Check only one)	nysician: To be best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or i	ath occurred a ny ligation,	at the time, date an in my opinion, dea	d place, and th occurred	due to the ca at the time, da	use(s) and manne ate and place, and	r as stated. due to the cause(s)
	To the within 2 To the complete	Med	29b. Signature and Alle of certifier	//	1	//	License number		25	d. Date signed (M	onth, Dav. Year)
)	1		• (1-6/1	1		1379	49	V	Lec, 3	12004
	ax 1		30. Name and address of person mo	completed cause of death (Ite	m 229 (Type	e, Print)	5, 91,0	nicki	W-040-3	Site 2	15T 2004 Her, MV), 21157
	St	ate	31. Date filed (Month, Day, Year)	32. Afgistrar's Sign	atur	(Jarle)					- - (13/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 39 200 02 08 AM Docomber **Physician** Wachter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner B. Itimire Merey N/A MidiL. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun 23, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 15 M 2□F 92 Yrs. Maryland 1912 213-03-4773 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State or 28a-f show traumatic avant, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 United States 8123 Analee Avenue permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If itam 27 Is marked other than "natural", or Itams 23a any injury or other traumatic event, the Walfaul East were reserved. Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: WW 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Tool & Dye Elementary/Secondary (0-12) College (1-4or 5+) Machinist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna Doefel George Wachter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Andrew J. Wachter, Jr./Son 3601 Crossland Avenue, Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan 4 1 Burial 2 Cremation 3 Removal from State Essex, MD Oaklawn Cemetery 2005 * 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility
Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Approximate Interval Between Onset and Death C. - dio my op. Thy Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physiclan: The law requires that the death certificate be executed use as the burial-transi attending physician and Due to (or as a consequence of): .O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one Be examiner Hospital: spital: 1 Inpatient 28a. Date of Injury (Month, Day Ye Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred 1 Natural 2 Accident 1 Tes 2 □No after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide within 24 hours a † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 301 St. Paul Plice #815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Whitehill **Physician** martin 25. 2004 December /Medical 4a. Fecility Name (If not institution, give street and number)

Harmony itall Assisted Giving 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HUNDO Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□F March 13, 1922 82 Maryland Director 219-03-0038 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depurtment of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a.4 are any injury or other traumatic event, Its Maryland. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 X No Director Baltimore Arbutus MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1212 Leeds Terrace 21227 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ellen Whitehill John Oliver Whitehill 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1212 Leeds Terrace, Arbutus, MD 21227 Judith Whitehill Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 18 Burial 2 Cremation 3 Removal from State Loudon Park Cemetery | 12-28-2004 Baltimore, MD 4 □ Donation 5 □ Other (Specify) of Funeral Service 22. Name and Address of Facilitymbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown

Pnysician /Medical **Examiner**

use as the burial-

attending physician

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To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funeral Director: After this certifics

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical by Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No 2 27. Manner of Death Certification: 1 Natural

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 Accident

4 Homicide

3 🗌 Suicide

29a. Certifier

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown

24a. Was an autopsy performed? Yes 25 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 □ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence

6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Ma

29d. Date signed (Month, Day, Year) D0050870 December 27th 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fell Lane Clarisulle MD 5005 Signal Bell Lane Clarisulle MD

State Registrar

'n

31. Date filed (Month, Day, 2005

5 Pending investigation

6 Could not be

determined

32 Registrar's Signature

reunone

Hospital:

Eric D. Ankrom Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpend item 23a,27, pent 1,031,05 ft. State of Maryland / Department of Health and Mental Hygiene 04-8296 **AKG** 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 24, **Physician** Eric Daniel Ankrom 2004 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number)
North Arundel Hospital 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Nov. 29 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral), 1971 Months Days Hours Min. 1**X** M 2□ F 33 218-86-4274 Yrs. Director MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "neturel", or items 23a or 28a-f shov other treumatic event, the Micrical Examinar in ust be notified at Broward Coral Springs FL Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2941 N.W. 92nd Ave. 33065 U.S.A death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white þ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. Ih and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) Diner College (1-4or 5+) Chef 12 years 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Ankrom Shirley Pittman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 is Daniel Ankrom 308 S. Cleveland Ave. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation—6 ☐ Other (Specify) ō permit. Page Department of Importent: If any injury or once. Big Pool, MD Parkhead Cem. Dec. 28, 2004 of Fugeral Service 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home
P.O.BOX 310 Clear Spring, MD 21722 Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cardiac Arrythnia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 2 🗆 No Yes 2□ No To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2CXER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E.

State Registrar

DHMH 17 Rev 1/2001

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OCAVICU. MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Pamela E-Southell, m.1)

December 24, 2004

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene) 4/632 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician 19 Amanda Jane Brown Dec. 2004 2:15 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Williamsport Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 XF Director 577-16-4647 WV Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryle ment of Haaith and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evan inner must be notified at MD Hagerstown 1 ☑ Yes 2 ☐ No Director Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21740 11 W. Baltimore St. Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 10 th Cook/Housekeeper Domestic Services 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Brown Amanda McCann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Siri Heinbaugh / Niece 16730 Hampton Rd. Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/23/04 Hagerstown, MD Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical aspiration pheumania Examiner Due to (or as a consequence of): by Physician/Medical Examiner cerebrovascula The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): dependen Due to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicel examiner? 26. Plece of Death (Check only one) Other: 4 . Nursing Home 5 . Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kuther-Sand, mil December 19 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Nursing Home Sands MD Williamsport - Kuttrer-

DHMH 16 Rev 6/95

Registrar

32. Registrar's Signeture

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last,	State of Marylan		artment of tificate of		R	eg. No.200	4 41633
	Physic /Medi	cal	Malcoma Roxie Brow 4a. Facility Name (If not institution, give	n		4h City Town	or Location of Dea	2. Date of Deat Month Dec. 20	Day Ye	10:30 P M
	Funeral	ier	Avalon Manor Nursi 5. Social Security Number 6. Security Number	ng Home 7. Age (In yrs. I	ast birthday) Yrs.	Hagers If Under 1 Year Months Days	town	8. Date of Birth	Washing	
	Director		212-24-3798 Usuat Residence of Decedent 10a. State 10b. County	99	r, Town or Lo	cation		09/07/1	905	MD 10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importent: if item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examinar must be redified at once.	by Funeral Director	MD Washingt 10e. Street and Number 57 Murph Avenue	on Haş	gersto	10f. Zip Code 2174			0g. Citizen of What US	1√2 Yes 2 □ No
9800	nours after de urei', or item il Exercitoria	d by Fune	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	□Yes 2XINo		Specify Yes or No- to Rican, etc.)		merican Indian, /hite, etc. Black
1215-	within 72 h ene. then "neti he Medica	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give I	ent's Usual Occu kind of work done OO NOT use retire COOK	during most of wo	rking	16b. Kind of Busine	
/land 2	ould be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) Frank Robison			COOK	18. Mother's Nai	me (First, Middle, M	Domestic Maiden Surmarne)	Services
, Mar,	and 2 sho ealth and I n 27 is me	•	19a. Informant's Name/Relationship (Ty, Thomas Cook / Great	t-Nephew	2123	Rolande:	r Street,	ural Route Number, Adelphi	City or Town, State, MD 2078	e, Zip Code) 3
Baltimore, Maryland 21215-0036	armit. Pages 1 spartment of He sportent: If iter ty injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Ros	se Hill	sition (Name of latory or other pla Cemete Name and Addre	ry 12/2	27/2004 I	Oc. Location - City Ia erstow Minnich	
8760,	ate be executed Wedical Washine burial-transit	dical Examiner	23a. Part1. Enter the disease, or comply shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in:tlated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	Ence of):			eet, Hage		Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 □I	Ectopic pregnance Other (specify)	y		23d. Date of o	delivery Day Year
ords, P.	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions con	tributing to death but not resul	lting in the un	derlying cause giv	ren in Part I.			to the cause of death? Probably 4 Dunknown
al Reco		Completed						24a. Was an autopsy perform	prior to	autopsy findings available o completion of cause of ? es 2□ No
Division of Vital Records,	f or Attending Physicien: The is alter death at alter death bus Director: After this certificate has in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Autural 5 Pending investigation 3 Suicide 6 Could not be determined	I Company of the Comp	R/Outpatient 28b. Time of Injury	28c. Injur Wor M 1	er: 4 ☑ Nursing H	th Check on one ome 5 Residen 28d. Describe how 28f. Location (Stre City or Town,	ce 6 Other (Sp	pecify) Rural Route Number,
	Hospitel 4 hours Funerel ely filled	edical Ce	29a. Certifier Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of my know ler: On the basis of examination and manner stated.	ledge, death on and/or inve	occurred at the tirestigation, in my o	me, date and place pinion, death occu	, and due to the cau	se(s) and manner a e and place, and di	as stated. ue to the cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		1. Date signed (Mon	
H	-3		30. Name and address of person who con Khalid M. Waseem, M	I.D. 1126 Opa	1 Cour	*	stown, M			
	Sta Registr	te ar	31. Date filed (Month 112 CY eg) 2 20	32. Registrar's Signatu	ire	and s				

Kenneth Boudrie

s Are Legible.

/giene

04-07975 MAN	For	State of Mary			insure All Copies alth and Mental Hy
Amended,4a	, ME ,1 - State Registrar	TCHD, 12/14/2004, sbb	Cei	rtificate of De	eath
Phys	1. Decedent's Na	me (First, Middle, Last)			2. Date of De
	dical KENNET	H BARTLEY BOUDRIE			Decemb
Exam	niner 4a. Facility Name	(If not institution, give street and number)	C:1.	4b. City, Town, or Lo	cation of Death
	2/943 -0s	kland Circle ^{Oaklands}	Ulrcle	Easton	

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, "Ite Medical Examiner is ust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - State TCHD, 12/	14/2004,sb	b <i>Cert</i>	tificate of L	Death	R	eg. No	104	4163	21.
Decedent's Name (First, Middle, Last) Date of Death								3. Time of Dea	ath
KENNETH BARTLEY	BOUDRIE				Decembe	er 11,	2004	1925 P	М
4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Dea	th	4c. Cour	nty of Death		
27943 Oakland Cir	cle Oaklan	ds Circle	Easton			Tai	lbot		
Social Security Number 6.		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1		place (State or For	reign
362-40-0550	1 XM 2 ☐ F	63 Yrs.	Wichidis Days	Tiodis Willi	JULY 20	1941	MĬČ	HÍGAN	
Usual Residence of Decedent		10.00							
10a. State 10b. County	0.00	10c. City, Town or Loca						10d. Inside City Lin	
MD TALB	OT	EAS'	TON					1 🕅 Yes 2 🗆]No
10e. Street and Number			10f. Zip Code		1	0g. Citizen o	of What Cou	ntry?	
27943 OAKLANDS	CIRCLE		2 1	1601			USA		
11. Marital Status	12. Was Decedent Armed Forces?		as Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		lace - Ameri		
1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 N	lo l	Yes XX No	Specify:	no (noan, stc.)	}	llack, White,		
3 ☐ Widowed 4 1 Divorced	Year or Dates:		I Tes ZIZINO	Specity.		Spec	siry: W]	HITE	
15. Decedent's E (Specify only highest gi	ducation	16a. Decede	ent's Usual Occupa	tion	nrkina	16b. Kind of	Business/In	dustry	
Elementary/Secondary (0-12)	College (1-4or 5	life. Do	O NOT use retired)		9				
12	5+	EXI	ECUTIVE			FUR	NITURI	E	
17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle, i	Maiden Sum	ame)		
KENNETH BENJAMI	N BOUDRIE			WAND	A FERGUS	ON			
19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	Address (Street a	nd Number or R	ural Route Number	City or Ton	m, State, Ziț	Code)	
MELISSA B. PETE	RSON/DAUGHT	TER 7574	17TH DRI	VE EAS	TON, MARY	ZLAND	21601		
20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Place of Disposi		- 1		20c. Location		own, State	
1 ☐ Burial 2 🖾 Cremation 3 [14 ☐ Donation 5 ☐ Other (Spec		CHESAPEAKI			12-13-200)/ STE	WENCU	TIE MD	
21. Signature of Funeral Service Lice	0000	22	Name and Address		12 13 200) T DIL	A PHO A 1	LILE, FID	
ME Day	110	FEI PEI			NEASTON,	M FUN	ERAL I	HOME PA	
220 Part 1 Enter the disease or our	V42W	CF 51 200					901		
23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each lin	ine death. Do not enter ie.	rtne mode or dying	r, such as cardia	ic or respiratory arr	est,		Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition	DNOW	sonse gu	militar	MOUN	0			Oriset and Death	,
resulting in death)		a consequence of):							
Sequentially list conditions,	b								
if any, leading to immediate cause. Enter Ur danying Cause (Disease or injury	Due to (or as	a consequence of):							
that initiated events	c.								
resulting in death) Last	Due to (or as	a consequence of):							
	_ d.								
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. E	Date of delive	∍ry	
in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live birth 4☐Pregnant at		Ectopic pregnancy Other (s <i>pecify)</i>			, A	Month	Day Year	
9 🗆 Unknown	9□ Unknown								
Part II. Other significant conditions	contributing to death be	ut not resulting in the und	derlying cause give	n in Part I.	23e. Did tob	acco use co	ribute to th	ne cause of death?	?
					1 □ Ye	s 2 No	3 🗌 Prob	ably 4 Unkno	own
					24a. Was a autops	y	prior to co	psy findings availa mpletion of cause	able of
					perform 1 □ Yes 2		death? 1 Yes	2□ No	
25. Was case referred to medical examiner?					ath (Check only on	e)			
1 X Yes 2 □ No	Hospital: 1 Inpatie	nt 2 ER/Outpatient	3 DOA Othe	r: 4 🗆 Nursing H	Home 5 ☐ Reside	nce 6x	ther (Specifi	At scen	ie.
27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day		28c. Injury Work		28d. Describe ho				
2 Accident investigation	on Found 12-	14:201			SHOT	SERF			
Suicide 6 Could not 1	28e. Place of Inju	iry - At home, farm, stree			28f. Location (St	reet and Nun	nber or Rura	l Route Number	410
- CITOMICIO	building, etc	(Specify)			279430A	,,		TOUT UUT	100
29a. Certifier 1 ☐ Certifying P	hysician: To the best of	of my knowledge, death of	occurred at the time	e, date and place	e, and due to the ca	use(s) and r	nanner as st	ated.	1
(Check only one) Madical Exa	miner: On the basis of and manner sta	examination and/or inve	stigation, in my op	inion, death occi	urred at the time, da	ate and place	, and due to	the cause(s)	-
29b. Signature and title of certifier			29c. License	number	25	9d. Date sign	ned (Month.	Day, Year)	
Maria	1 1800) 140	0.C.					,	
mayore !	me your	FUY		гт Ľ	L	ecembe	er 12,	2004	
30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pr	rint)						

State Registrar

MANYS MANS
31. Date filed (Month, Day,

A. KOREU

32 Registrar's Signature

111 Penn Street, Baltimore, Maryland, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MAUDE BRAY **Physician** December 5,2004 10:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Joseph Rickey Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F 74 Washington D.C. 579-36-9182 Director May 26,1930 Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10a State 10h Count or 28a-f show item 27 is marked other then "naturel", or iteme 23s or 28s-f ebov other treumstic event, its Marica Exporter marker native and 1 X Yes 2 □ No Director MD Baltimore <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 838 Eutaw Street 21201 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event Walter Raymond Harrison Maud Matilda Gayleard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 Upton Road, Severn, MD 21144 Maureen Mary Tipton/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 12/9/2004 Suitland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Codnr Hill Funeral HOme, Inc. 21. Signature of Funeral Service Licana 4111 Pennsylvania Avenue, Suitland, MD 20746 and and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONE YEAR METASTATIC COLON Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate to the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physicien: within 2

Registrar

DHMH 17 Rev 1/2001

cal

LOUGLAS. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6114

and manner stated.

29c. License number

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

DO026327

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAMPFIRE, COLUMBIA, Registrar's Signature

29a. Certifier

(Check only one)

		•	For State Registrar	State of Maryla		artment of Hertificate of E			giene 0 4	41636
	Physicia /Medic		Decedent's Name (First, Middle, Last) MARY	A. BUI	DEBER(3		2. Date of Dea Month DEC •	9,2004 Yea	3. Time of Death 11:50P M
	Examin		4a. Facility Name (If not institution, give s Layhill Center			4b. City, Town, or Silver			4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		1905 I	inthplace (State or Foreign Country) Laly
	faryland show ed at	o.	Usual Residence of Decedent 10a. State 10b. County MD Montgo		City, Town or Lo	cation er Sprin	g			10d. Inside City Limits 1 ☐¥es 2 ☐ No
	with the Na or 28a-1	Director	10e. Street and Number 3227 Bel Pre F	-		10f. Zip Code 209	0.2		10g. Citizen of What	•
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other treumatic event, the Medical Examenar must be notified at a contract of the cont	by Funeral		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar		Specify Yes or No- to Rican, etc.)	0	nerican Indian, nite, etc. Thite
Maryland 21215-0036	thin 72 hour e. an "natural" Medical Ex	Completed b	15. Decedent's Edu (Specify only highest grack Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occupa kind of work done d DO NDT use retired)	uring most of wo	prking	16b. Kind of Busines	
and 21	d be filed wi intal Hygien ted other th	Be	4th 17. Father's Name (First, Middle, Last) Angelo Dis	stefano		Domestic	18. Mother's Na		Home Maiden Sumame) Lintini	
Mary	ind 2 shoul aith and Me 27 is mark ar treumati	P.	19a. Informant's Name/Relationship (Ty Phyllis Genson-	grand Grand daughter	1180	8_Eton M	lanor D	r#202 (or, City or Town, State Germantov	vn, MD20876
Baltimore,	permit. Pages 1 a Department of He- Importent: If item any injury or othe		20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	M M	deministery, created to F	sition (Name of matory or other place nr1. SVS	12/	Date /11/04	20c. Location - City Alexandi	or Town, State
Balt	permit. Depart Import any inj		21. Signature of Fineral Service Locals	Ausuch	1 2	46 N Was	hingto	n St Ro	ckville	
	Physician /Medical Examiner		23a. Pert1. Enter the disea se, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the de ne cause on each line. Due to (or as a cons	auco	er the mode of dying	, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Each of sarying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	lelivery Day Year
rds, P.	w requires that the been signed by the should be detache	þ	Part II. Other significent conditions con	ntributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did to		to the cause of death? Probably 4 Unknown
of Vital Records,	e law has b	Completed			,			24a. Was autop perfor	sy prior t	
Vita	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		eath (Check only o		
on of	fing After fune	tlon: To	1 Yes 2 No 27. Manner of Death Natural 5 Pending Accident investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injury Work	at		lence 6 □Other (S) low injury occurred	эвспу)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f. Location (S City or Ton	Street and Number or m, State)	Rural Route Number,
	ne Hospitel n 24 hours a ne Funerel i	ledical (29a. Certifier (Check only one) 2 Medical Exemi	sicien: To the best of my l ner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occ	urred at the time,	date and place, and d	ue to the cause(s)
)	1000	M	29b. Signature and title of certifier	Alers (Da Mi	29c. License	826	2	29d. Date signed (Mo	nth, Day, Year)
	5		30. Name and address of person who co	ompleted cause of death (I	item 23a) (Type,	Print) HIRAT	(A)2	401 RE Suite	330 Roc	ECULLE MD
	Sta Registi		3f. Date filed (Month, Day, Year) DEC 13 200	32. Registrar's Si	gnature 5	Sparks	,			

Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Itama 23a or 28a-f ehow any injury or other traumatic event. The Modical Examiner, wat be notified at once.

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

- State Unpend Item 2	3a,pt.11,2/ p	er me	tifficete of t	reath 1	tas	R	eg. No	01. 1	100
. Decedent's Name (First, Middle, Last)					2	2. Date of Dea		UH	Time Doath
Megan A. Benso	n					Month Decembe	Day er 26.	2004 (03:50 A
a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of				y of Death	
6845 Sunderling Con			New Mark		ld Heal La			rick Co	
205-74-1652	7. Age (In yrs. I	Yrs.	Months Days	If Under 2 Hours	Min. J	(Month, Day)	, 1994	9. Birthplace Country) Pennsy	(State or Forei 1vania
Sual Residence of Decedent Oa. State 10b. County	10c. City	y, Town or Lo	cation					104	Inside City Limit
		New Mai							1 ☐ Yes 2 ☑ N
Maryland Frederick Oe. Street and Number	·	vew Mai	10f. Zip Code				Og Citizon of	What Country	
6845 Sunderling Co	urt		2177			'	17	ed State	
	2. Was Decedent Ever in U.	S. 13.1			in? (Speci	fv Yes or No-		ce - American	
1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 [X]No		Was Decedent of Hi f Yes, specify Cubar	, Mexican,	Puerto Ri	can, etc.)		ck, White, etc.	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:			Speci	<i>fy:</i> Wh:	lte
15. Decedent's Educ	ation	16a. Deced	dent's Usual Occupa	tion	-4:4:1		16b. Kind of E	Business/Indus	ry
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done d DO NOT use retired,	uring most	of working	'			
5			Student				E1eme	entary	School
7. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle, I	Maiden Suma	me)	
Unknown				Elai	ine L	. Benso	on		
19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street a	nd Number	r or Rural I	Route Number	City or Town	, State, Zip Co	de)
Elaine L. Benson /			Sanderlin	g Cou	ırt	New Ma	ırket,	Marylar	nd 2177
0a. Method of Disposition		lace of Dispo	sition (Name of natory or other place		Dat		20c. Location	- City or Town,	State
1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	movar nom otato		Cremator	: 10	ecemb 0, 20		Freder	ick, Ma	rvland
21. Signature of Funeral Service License			. Name and Addres				ineral	Homes,	P.A.
DAG TX	panerir		521 Oposst						
Sequentially list conditions, b. any, leading to immediate ause. Enter Underlying ause to the condition of the conditions of the condition of the conditions of the condition	Due to (or as a consequence to (or as a consequence)								
esulting in death) Last	Due to (or as a consequ	uence of);							
FFEMALE: 23 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	ic. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)					ate of delivery onth Day	/ Year
art II. Other significant conditions cont Cerebral palsy	ributing to death but not resu	alting in the u	nderlying cause give	n in Part I.		23e. Did tob	✓ ✓	tribute to the c	
						24a. Was a autops perform	y ned?	Were autopsy prior to comple death?	findings availab
5. Was case referred to medical				26. Place	of Death /	1 Yes 2 Check only on	e) No	1	, .10
examiner? 1 ☐XYes 2 ☐ No	ospital:	ER/Outpatien	t 3 DOA Othe			5 🗆 Reside		ner (Specify)	At scen
7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28	d. Describe ho			
3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28	f. Location (St. City or Town		ber or Rural Ro	ute Number,
29a. Certifier 1 Certifying Physic Check only 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the time vestigation, in my op	e, date and nion, death	place, and occurred	d due to the ca at the time, da	use(s) and mate and place,	anner as stated and due to the	i. cause(s)
19b. Signature and title of certifier	wo		29c. License	number CME			_	ed (Month, Day	
Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print)						land 21

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month DEYC 2 8 2004

			Please	State of Man				_		Jibie.	
		•	for State Registrar	Otate of Ivial		rtificate o		Worker Try	Reg. No.	04	41638
	0		1. Decedent's Name (First, Middle, Las		1.			2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic		Arthur	H. 131	oché			Dec.	8, 2	2004	1:00 p M
	Examir		4a. Facility Name (If not institution, give				, or Location of Deat			nty of Death	
L			Genesis ElderCare		n yrs. last birthday		verna Parl				Arundel
	Funeral Director		5. Social Security Number 6. S 070-14-7630 Usual Residence of Decedent	M 2□F	84 Yrs.	Months Day		(Month, Da	ay, Year) 20, 1920		hplace (State or Foreign untry) NY
	land ow		10a. State 10b. County	10	0c. City, Town or L	ocation					10d. Inside City Limits
	Mary	to	MD Anne A	rundel		Anna	polis				1 ☐ Yes 2X No
	th the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o		untry?
	ath w	ral	1601 Pencay Court				21401		144.5	USA	
	er de Itams	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	If Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	0- 14. H	lace - Amer lack, White	rican Indian, e, etc.
36	vurs after death with the Marylan at', or Itams 23e or 28e-f show Examiner must be mutitied at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Styes 2 No If Yes, Give Year or Dates:	WWII	1☐Yes 2🗓N	lo Specify:		Spec	city:	White
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23a or 28a-f show ont, tra Madical Eraminat must be notified a	Completed	15. Decedent's Ed (Specify only highest gra	Jucation de completed)	(Give	edent's Usual Occ e kind of work doi DO NOT use reti	ne during most of wo	rking	16b. Kind of	Business/I	ndustry
12	withir ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		Stock B	•		Fi	inanci	ial
2	illed within Hygiene. other than rent, tre M	BeC	17. Father's Name (First, Middle, Last)	1	ŀ		18. Mother's Na	me (First, Middle	, Maiden Sum	ame)	
<u>la</u> n	o d ta	To B	Arthur E. Bloche				Gertruc	de Robin	son		
ary	s 1 and 2 should if Health and Men item 27 Is marka other traumatic		19a. Informant's Name/Relationship (Туре, Print)	19b. Mail	ing Address (Stre	eet and Number or Ri	ural Route Numb	er, City or Tow	m, State, Z	ip Code)
	1 and 2 Health Iem 27 other tra		Jeanne R. Bloché				Court, Ar	napolis		21401	T 01-11
ore			20a. Method of Disposition 1 Burial 2 Coremation 3		•	ematory or other p	Dec	. 10,	20c. Location		
altimore,	t. Par rtmen rtant: njury		` 4 □Donation 5 □Other (Specif			rematory 2. Name and Add	/	2004	Balti	more,	CIM
Ba	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer		ĺ	Barranco	& Sons, I	P.A. Sev	erna Pa	ark Fi	uneral Home MD 21146
			23a. Part1. Enter the disease, or com	plications that caused th						ILK, I	Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	One cause on each line.	1-1	.* So					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	consequence of):	1 one					
	Examiner		Sequentially list conditions	b ktype	teurion						
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a c	consequence of):	11 -+ -					
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):	llation					
90	eath certificate be executed attending physician and for use as the burial-transit	calE		d WA	,						
687	flicate physics the										
Вох	The law requires that the death certificate to has been signed by the attending physings 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		□Ectopic pregna	DCV			Date of deliv	*
	death	sicia	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4☐Pregnant at tim		Other (specify)			'	Month	Day Year
<u>Р</u> О	res that the de signed by the a be detached t	Phys	9 Unknown		and an authin a in the		enven in Deet I	22a Did	tobacco uso co	ontribute to	the cause of death?
	res th signed	by	Part II. Dther significant conditions of	ontributing to death but r	not resulting in the	ungeriying cause	given in Part I.	1	Yes 2 □ No		
Vital Records,	w require been sij should b	Completed						24a. Was			
Zec	The law cate has page 2 s	ld m						auto	psy ormed?	death?	topsy findings available completion of cause of
a			25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only	2 No	1 🗆 Yes	2 ⊠ ,No
5	Physiclan: r this certifica ral director, p	o Be	examiner?	Hospital:	2 ER/Outpatie	ent 3 DOA	Other	dome 5 ☐ Resi		ther (Spec	eify)
10	g Phy er thii	T i	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time		njury at Vork?	28d. Describe	how injury occ	urred	
0	teath. tor: After th the funeral	atlo	1 Natural 5 Pending 2 Accident investigatio	n			☐Yes 2☐No				
Division of	or Attracted blrected in by the	Certification;	3 Suicide 6 Could not be determined			treet, factory, offic	ce	28f. Location (City or To	Street and Nur wn, State)	nber or Rui	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the funeral director,			nysician: To the best of or							
	the H in 24 the Fi	Medical	one)	miner: On the basis of ex and manner stated							
	To To	2	29b. Signature and title of certifier	DI	100		ense number		29d. Date sign		
,			I V V	100	0101911		056950		Ja Cem	100 7	1,2004
			30. Name and address of person who	completed cause of deal	1 .	^	056950 BWD A	nito A	Paral	Page 6	MD 21122
	Sta	ite	31. Date filed (Month, Day, Year)	32. Poistrar's		Naynov	VV 0 0 0	nio n	1 - 000	- 1111	my KIIK
1.	Renist		DEC 13	2004	Lo	1 .					

			1- For Amend Item 5 per 15 Registrar	f ()(8339 land :/_103 0a <i>Cei</i>	uagent of Health and I		ne No2004	41639		
	Physici /Medic		Decedent's Name (First, Middle, Last) GEORGE WILLIAM BAUDE				Day Year 11,2004	3. Time of Death 10:30 A ^M		
	Examin		4a. Facility Name (If not institution, give street and nu HERITAGE HARBOUR HEALTH		4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUND	EL		
	Funeral Director		5 Social Security Number 6. Sex 1 X M 2 F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye NOV . 10 . 19	ar) Count	ace (State or Foreign ry) YLVANIA		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Midical Ever-liner real ke notified at	To Be Completed by Funeral Director	Armed File Never Married 2 Married 1	ANNAPOLIS 2. Street and Number 3. Street and Number 4.47 RUDDER WAY Amailal Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18. Mother's Name (First, Middle, Last) EORGE W. BAUDE 19b. Mailing Address (Street and Number or Rural Route Number, Citementary) 19b. Mailing Address (Street and Number or Rural Route Number, Citementary) 19b. Mailing Address (Street and Number or Rural Route Number, Citementary) 20b. Place of Disposition (Name of Camberla) 20c. Place of Disposition (Name of						
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe		20a. Method of Disposition 1	2-04 EDO	EDGEWATER,MD. 21037					
8760,	Physician pe executed under physician and physician and proper as the purial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	caused the death. Do not entered and line. (or as a consequence of): (or as a consequence of):	ter the mode of dying, such as cardiac	cor respiratory arrest,		Approximate Interval Between Onset and Death		
O. Box 6	death certific e attending p id for use as	Physician/Medical	23b. was decedent pregnant 1 Live	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ry Day Year		
Records, P	law requires as been sign 2 should be	Completed by Pl	Part II. Other significant conditions contributing to a	death but not resulting in the u	nderlying cause given in Part I.	1 ☐ Yes 24a. Was an autopsy performed	24b. Were autop prior to con death?	ably 4 Sunknown osy findings available optetion of cause of		
Vital		e Co	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 🔯	No 1 □ Yes	219PN0		
ö	ing Ph n. After th funeral	ToB	examiner? 1 Yes 2 No Hospital: 1 27, Manner of Death 28a. Date	Inpatient 2 ER/Outpatien of Injury nth, Day Year) 28b. Time of Injury		flome 5 Residence 28d. Describe how	e 6)		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farm, st ding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural State)	Route Number,		
	the Hospit in 24 hour the Funera	edicai	(Check only 2 Medical Examiner: On the one) and ma		th occurred at the time, date and place ivestigation, in my opinion, death occu	arred at the time, date	and place, and due to	the cause(s)		
)	with To	M	29b. Signature and title of certifier	D	29c. License number D 38958	12	Date signed (Month, L	Jay, rear)		
	Sta Regist		30. Name and address of berson who completed cauding and address of berson who completed and address o	ise of death (Item 23a) (Type.	nifily brad	#106 0	denton 1	4D21113		

C HEEZUM, JOHN

1. Decedent's Name (First, Middle, Last)

Certificate of Death

2. Date of Death

1. Decedent's Name (First, Middle, Last) Physician (Medical JOHN W. CHEEZUM							2. Date of D Month Decem	Day	16 200 h	3. Time of Death	
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, of	or Location of De		4c.	County of Death	
	Funeral Director			H 05 P I 7. Age M 2 □ F	(In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days			irth ay, Year)	9. Birth OMAR	7 place (State or Foreig Intry) YLAND
	e Maryland ie-f show	ctor	10a. State 10b. County MD CAROL 2	INE	10c. City, Town or Lo	ecation ENSBORO	-				10d. Inside City Limits 1 X Yes 2 □ No
	h with the	ai Dire	10e. Street and Number 100 KITTERIDGE (COURT		10f. Zip Code 2163	19		10g. Citizen of What Country?		
920	72 hours after death with the Maryland neture!', or Itams 23a or 28e-f show Itsal Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	,	Was Decedent of H If Yes, specify Cub	Hispanic Origin? an, Mexican, Pue	(Specify Yes or N erto Rican, etc.)			ican Indian, , etc.
21215-0036	filed within 72 ho Hygiene. other than "netur ent, the Medical.	ompieted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. I	dent's Usual Occup kind of work done DO NOT use retire	oation during most of w d)	rorking		ind of Business/Ir	,
land ;	ld be filed ental Hyg ked othe to event,	To Be C	17. Father's Name (First, Middle, Last) CHARLES H. CHEEZU	JM				ame (First, Middle	, Maiden	Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	-	19a. Informant's Name/Relationship (Ty	rpe, Print)		ng Address (Street	and Number or I	Rural Route Numb	er, City o	r Town, State, Zij	
Baltimore,			DAVID L. CHEEZUM/SON PO BOX 773 OLD ORCHARD BEACH, MAINE 0400 20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PO BOX 773 OLD ORCHARD BEACH, MAINE 0400 20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY 12-21-2004 HILLSBORO,								own, State
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens OSPA M OSPA	wsh' C.F.S	A FE	Name and Addre ELLOWS, H OO S. HAR	ss of Facility ELFENBE	IN & NEWI	NAM F	UNERAL 1	
	Anysician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	$\frac{Non 5}{}$	he death. Do not ente	er the mode of dyir	ng, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
68760,	death certificate be executed e attending physician and d for use as the burial-transit	icai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of):						
O. Box	the death certifica y the attending ph ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy			2	23d. Date of delivery Month Day Year	
rds, P	law requires that the de as been signad by the a 2 should be detached f	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.				he cause of death?
I Records,	9 - 9	Completed						24a. Was auto perfo	an psy ormed? 2 XI No	prior to co death?	psy findings available mpletion of cause of 2 No
f Vital	Physician: The this certificate ral director, pag	To Be (25. Was case referred to medical examiner?	lospital:	t 2 ER/Outpatient	t 3□ DOA Oth		eath (Check only of Home 5 ☐ Resi	one)	i ∏Other (Specif	iv)
ion of	fte ng		27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Time of 28c. Injury at 28d. Describe how injury occurred					
27. Manner of Death Valuatural Description To be the control of					eet, factory, office						

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation in my original death occurred at the time death occurred at the time.

8. Washington St Castm no 2/601

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of

nd addres of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Statė Registrar

32. Registrar's Signature

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ORIGINAL

DHMH 17 Rev 1/2001

To the Hospitel or Attending Physician: The

within 24 hours after death. To the Funerel Director: A

Medical Certification: To

			State of Maryland / De	epartment of Health ar Certificate of Death	nd Mental Hygie	
	Physicia	_	Decedent's Name (First, Middle, Last) BRAMO COBB		2. Date of Death Month Decembe	Day Year 2004 1:40 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Clinton	Death	4c. County of Death P.G. CO.
Ĺ	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtholds) 1×10^{-1} 1×1	Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Ye 0 4 / 26 / 1	
	death with the Maryland ms 23a or 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Decedent MD P.G. Co. Uppe:	r Location r Marlboro		10d. Inside City Limits 1
	or 28a	Direc	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	death w	Funeral Director	13152 Ripon Place 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	20772 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? (Specify Yes or No-	U.S.A. 14. Race - American Indian, Black, White, etc.
220	within 72 hours after death with the Marylan ene. Itan "natural", or Items 23a or 28a-f show Ita Madral Examinar must be notified at	þ	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ ★ O Specify:	dono modificación	Specify: Black
2-0-1		Completed	(Specify only highest grade completed) (College (1.40r 51)	ecedent's Usual Occupation Give kind of work done during most of 1e. DO NOT use retired)	of working	b. Kind of Business/Industry
V	led with tygiene. har thai		5th Ra:	ilroad Freight	s Name (First, Middle, Mai	Private
	s 1 and 2 should be filed within if Health and Mental Hygiene. itam 27 is marked othar than other traumatic evant. It a Me	To Be	Sam Cobb		osa (Not A	
Mary	12 should a and Men ris marke		19a. Informant's Name/Relationship (Type, Print) 19b. Namekia Davis - Grand-Daug. 1	Mailing Address (Street and Number		
nore, r			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place)	Date 200	c. Location - City or Town, State
Dalillinor	permit. Pages Department of Important: ff i any Injury or o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Freeman F	uneral Services
	Physician		23a. Part1. There the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	enter the mode of dying, such as ca	SUITIANO ardiac or respiratory arrest.	Maryland 20752 Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of) Sequentially list conditions	reline Soul	tion	antino
	be executed iclen and purial-transit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)			
8/00,	icate be executed physiclen and s the burial-transit	dicai Ex	d			
O. DOX O	death certif e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
ds, r.	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		cco use contribute to the cause of death?
Records	siclan: The law rec certificate has bee irector, page 2 shou	Completed			24a. Was an autopsy performer 1 Yes 2	
VIII	Physiclan: this certifica ral director, p	Be	25. Was case referred to medical examiner?	Other	f Death (Check only one)	200 (200
SION OI	ng Phy fter this meral d	tion: To	27. Manner of Death 1 Datural 5 Pending 2 Accident Accident To Death Injury 2 Revision 1 Death (Month, Day Year) 2 Revision 2 ER/Outp. 28a. Date of Injury (Month, Day Year) 28b. Tin (Month, Day Year)	ne of 28c. Injury at	28d. Describe how	
DIVISI	To the Hospital or Attending F within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	281. Location (Stree City or Town, S	st and Number or Rural Route Number, State)
	a Hospite 124 hours 6 Funara letely fille	edical C	29a. Certifier (Check only one) 1 Dertifying Physician: To the best of my knowledge, (2 Medical Examiner: On the basis of examination and/one)	death occurred at the time, date and or investigation, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier ARAKTON YOUTH	29c. License number		Date signed (Month, Day, Year)
K	(6)		30. Name and address of person who completed cause of death (Item 23a) (T)	(pe, Print) 3-41 Silve	> Spainsm	10 20902
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 3 2004 Registrar's Signature—	hoole	3, ,,,	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 13

2004

CHBNE

MARCARE

32. Pegistrar's Signature

		State of Maryland / Department of Health and Mental Hygiene 1 - State Reg No 0 0 1 1 1 0 1								1610					
			Registrar 1. Decedent's Name (First, Middle, Last)	The grant of the state of the s					2	2. Date of Death 3. Time of Death					
	Physicia		Charlie Oliver Crown						Month Day Year December 15 2004				7:55am ^M		
	/Medic Examin		4a. Facility Name (If not institution, give st				Town, or	Location of				County of De		7 . J J d III	
	xaiiiii	•	9800 Fields Road				Gai	ithers	burg		:	Mont	gome	erv	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Unde Months	1 Year Days	If Under 24 Hours		Date of Birth (Month, Day,	Year)	9. Bi	irthplace	e (State or Foreign	7
Ш	Director		215-20-9263	78	Yrs.				A	ug. 1	1926	M		land	_
21215-0036	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation				12477			10d.	Inside City Limits	
	Maryl f sho	jo	Marsal and Marshaum	0-15	1 1									1 ☐ Yes 2 🖾 No	
	the restil	Director	Maryland Montgomery Gaithersburg 106. Street and Number 109. Citize							zen of What C	Country	?	_		
	death with the Maryland ms 23s or 28s-f show		9600 Fields Road				20	0878			Un	ited S	tate	es	
	deat	Funeral		Was Decedent Ever in U.S. Armed Forces?	13.	Was Dece	dent of Hi	spanic Origi	in? (Speci	fy Yes or No- can, etc.)		14. Race - Am Black, Wh	nerican	Indian,	
	or it		1 Never Married 2 Married	1 ∐Yes 2 ∰No If Yes, Give	1	1 🗆 Yes		Specify:		, 0.0.,		Specify:			
	filed within 72 hours after Hygiene. Ither than "natural", or Ita ont, the Medical Examine	d by	3 ☑Widowed 4 □ Divorced	Year or Dates:	16a. Dece	danela Hav	al Ossus	tion.					Whi		
Ϋ́	n 72 n "nal	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of wo DO NOT u	rk done a	lurina most o	of working		IOD. KI	nd of Busines	s/indus	try	
7.	with iene. ther	шо	Elementary/Secondary (0-12)	College (1-4or 5+)		Farm	er					Farmi	no		
	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "naturel", or items 23a or 28a-f show avent, the Medical Examiner must be rediffed at	a)	17. Father's Name (First, Middle, Last)					18. Mother's	s Name (First, Middle, I	Maiden				_
<u>a</u>		To B	Forrest F. Crown					Ruby	Brig	gs					
Maryland	sh and s m	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address	(Street a	ınd Number	or Rural I	Route Number	City or	Town, State,	Zip Co	de)	
_	an eal eal n 2 n 2		Catherine Stinson/					Road,		hersbur					
0	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	e of Dispo etery, crei	natory or o	other place		Dat			cation - City o			
Baltimore,	tmen tant:		' 4 ☐ Donation 5 ☐ Other (Specify)						2/18,	/2004	Fre	derick	, Ma	aryland	_
g	permit. Page Department of Important: If any injury or once.	1 10	21. Signature of Feneral Service License	Ugen	01	in L	. Mol	s of Facility Leswor Road	th P Dai	A. Fu	ner Ma	al Hom ryland	e 208	872	
			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Final Control of Canada Cause (Final Control of Canada Cause) Example 1												
	Pnysician	í 1													
	/Medical Examiner		resulting in death) Due to (or as a consequence of):												
	Examino	Examiner	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):									-		_	
	ted nsit		cause. Enter Underlying Cause (Disease or injury										ļ		
,	execun and ial-tra	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):								_				
09/8	icate be executed physician and s the burial-transit	dical	d												
٥	ng ph as th	/ledi	IF FEMALE:												
X R R	leath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months? 1							2	23d. Date of delivery Month Day Year				
0	iaw requiras that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me									and the same of th				
7.	that the								23e. Did tot	Displaced use contribute to the cause of death?					
ecords,	w requiras that been signed b should be deta	d by	•			, ,				1 □ Ye	s 2\v	√No 3□F	robably	y 4 ∐Unknown	
	w req	lete								24a. Was a	n	24b. Were a	autoosv	findings available	_
Y Y	9 4 9	Completed								autops	y ned?	prior to death? 1 \(\sum \) Ye	comple	etion of cause of	
Division of Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical					26. Place o	of Death (1 Yes 2	e) No	10.46	5 21		-
	S S	To B	examiner? Hospital: Other						sing Home	Home 5 Residence 6 Other (Specify)					
	ng Ph fter th									d. Describe ho	Describe how injury occurred				
	eath. or: A the fu	catle	Accident investigation		M 1 Yes 2 No										
$\frac{1}{2}$	or Ati	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)								cation (Street and Number or Rural Route Number, y or Town, State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one) Certifying Phys	icien: To the best of my knowle er: On the basis of examination	edge, deat	h occurred vestigation	at the tim	e, date and pinion, death	place, an occurred	d due to the ca at the time, d	ause(s) ate and	and manner a	as state	d. e cause(s)	
	o the ithin ; o the omple		29b. Signature and title of certifier	and manner stated.	1. 1	29	c. License	number		2	9d. Date	signed (Mor	nth, Day	, Year)	-
	⊢ ≶ ⊢ ö		> tatuera Tom	spe May,	MAS)519	16		Dec	ember	1 /5	,2004	
	* -		36 Name and address of person who completed cause of death (Item 23a) (Type, Print)										-		
_	V		Patricia Tomsko Nay, 111/1 Rockville Pike, G-100, Rockville, IND 20852												
	Sta Registr		31. Date filed (Month, Day, Year)	2004 Signatur	0	Asso	Sec. 2								
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State of Maryland / Department of Health and Men	tal Hygiene 004
Certificate of Death	Dec No.

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			gienę? () Reg. No.	104	41644		
	Physici		Decedent's Name (First, Middle, Las KENNETH ALF)	•		2. D			Year Of	3. Time of Death			
	/Medio Examir		4a. Facility Name (If not institution, give	Berlin			4c. Coun	4c. County of Deeth Worcester					
	Funeral Director		5. Social Security Number 6. Security Number 221-12-9626 Usual Residence of Decedent	x 7. Age	(In yrs. last birthday) 79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/4/19	r, Year)	9. Birthol Coun	lace (State or Foreign try) MD		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Itema 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	Director	10a. State 10b. County MD Worces		10c. City, Town or Lo				0d. Inside City Limits 1 X Yes 2 □ No				
			11630 N. Dolly Circle			10f. Zip Code	811		10g. Citizen of US		try?		
-0036		ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	wwii	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo dent's Usual Occup	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra	ice - America ack, White, e	etc. Nite		
Maryland 21215-0036		Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of wor	king		gboat	and strip		
yland		To Be (17. Father's Name (First, Middle, Last) Charles Davis				Edna	ne (First, Middle, a Carver	•	·			
Mar			19a. Informant's Name/Relationship (7) Etta M. Davis	ype, Print)		ng Address (Street a				a, State, Zip 2181			
Baltimore,			20a. Method of Disposition 1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		20b. Place of Dispo cemetery, crea Riversid	e Cemete	ry 12/	Date 22/04	20c. Location	- City or Tov	wn, State , MD		
Balt			21. Signature of Funeral Service Licens	"Y. Ray	Starty	2. Name and Addres	ss of Facility Th	e Burba erlin, M	ge Fui D 218	neral	Home		
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and in position of the funeral director, page 2 should be detached for use as the burial-transit at the united of the funeral director.		ha. Part1. Enter the lisease, or on the shock, or heart ailure. List only of Immediate Cause (Final disease or condition resulting in death)	a. VW2		ter the mode of dyin	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death		
		dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Du to (or sa	co sequence of):	Kién	lly (deseos	e	1.	ke long		
O. Box 6		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		Pi		ate of deliver	ry Day Year		
rds, P.		þ	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tol	_/		e cause of death?		
Division of Vital Records,		Completed						24a. Was a autops perform	iy _	prior to com death?	sy findings available apletion of cause of		
Vita		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Hespital: 6 Other (5)										
ion of		ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?					28d. Describe how injury occurred				
Divis		Certific	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
		edicai	29a. Certifier 1 ☐ Certifying Phy cone) 1 ☐ Certifying Phy 2 ☐ Medical Example 1 ☐ Me	rsician: To the best of iner: On the basis of e and manner state	examination and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, da	ause(s) and mate and place,	anner as sta and due to t	ited. the cause(s)		
	To the within 2 To the complete	Me	29b. Signature and title of certifier	16ci		29c. License		2	9d. Date signe	ed (Month, D	ay, Year)		
, I	A		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) (Type.	H44	183		12/3	10/0	4		
H	,54		Robert Du	1/Kin	9733	Hell.	hay	Drine	Be	len	, 22)		
160	Sta Registr	-	31. Date filed (Month, Day, Year) BEC 2 1 20	32. Régistrar	s signature	me	1						

DHMH 17 Rev 1/2001

Kenneth Divis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, flown, or Location of Death 4c. County of Death Examiner 7. Age (In y/s. last birthday) 0 orces If Under 1 Year | If Under 24 Hrs. Ter 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 🛣 F 224-28-595 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23a or 28e-f show the Medical Examinat must be indiffed at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No B Specify: 3 Widowed 4 □ Divorced 191 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be avage 19a. Informant's Name/Relationship (Type, Fint), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter—10 Disposition (Name of cemetery, crematory or other place) Willowgrous Ave allaroc 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 0 22. Name and Address of Facility Revolt 21. Signatura of Funeral Service Licensee , Box 331 Po como Kc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause Final disease or condition resulting in death) ADVANCED Physician DEMENTIA /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transit TYPE To the Hospitel or Attending Physician: The law requires that the death certificate be executed I DIABETES Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 □ Yes 2 No
9 □ Unknown Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 110 certificate 1 ☐ Yes 2 **N**O 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00062172 12/15/2004. a JAMAL, MID SHARAD

DHMH 17 Rev 1/2001

State

Registrar

MARKET

POLOMOKE

CITY

MI)

21851

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHARAD R SATYAL 1604 MARKET ST

1 7 2004

31. Date filed (Month, Day, Year)

1604

32 Registrar's Signature

			For	State of Maryla		artment of		nd Mental Hy	giene 00	4 41646				
			Registrar 1. Decedent's Name (First, Middle, Last)		Ce	Tillicate of	Dealli	2. Date of De	Reg. No.	3. Time of Death				
	Physici /Medio	al	Janet Elizabeth De			41 Gi T		December 1	x 16 200	10:35 AM				
*	Examin	er	4a. Facility Name (If not institution, give s Washington County			4b. City, Town,		Death	4c. County of					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	Hagerst	r If Under 2	4 Hrs. 8. Date of Big Min. (Month, Da	Washing	Birthplace (State or Foreign Country)				
	Director		233-44-5370 Usual Residence of Decedent	^{M 2} ♥ 76	Yrs.	World bay	Tiours	Jan, 2		est Virginia				
	aryland show	_	10a. State 10b. County		ity, Town or Lo	ocation		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits				
	the M	Funeral Director	Maryland Washingtor 10e. Street and Number	n Hag	gerstow	n 10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citizen of Wh	1 Yes 2 No				
	3e or	ā	17719 Red Oak Drive	9		21740			U.S.A.	at Country :				
	deatl	nera		12. Was Decedent Ever in I	J.S. 13.		Hispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)		American Indian,				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Itams 23e or 28e-1 show appriants of items 23e or 28e-1 show appriants of the recomments event, the Medical Examination used to notified at angree.	by Fu	1 ☐ Never Married 2 📉 Married 3 ☐ Widowed ·4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ì	1 ☐ Yes 2XX No		rueno rican, etc.)	Specify: W	White, etc. Thite				
21215-0036	72 hou nature	eted !	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occu	upation	of working	16b. Kind of Busin	ness/Industry				
121	within "ne. Than "u	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	or working						
	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)		Secre	tary	18. Mother	's Name (First, Middle	Insuranc	e				
Maryland	Jental Jental rked c	To Be	John Rohrbaugh					Lee Whitta						
lar	2 sho and h Is ma		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	ng Address (Stree	at and Number	or Rural Route Numb	er, City or Town, Sta	ate, Zip Code)				
	1 and Health em 27 ther tr		Robert F. Deadrick		17719 Place of Dispo	Red Oak	Dr. H	agerstown Date	Maryland 20c. Location - Cit					
Baltimore,	ages ant of t: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	amovat nom state		sition (Name of matory or other plants	!							
altir	mit. Foorten		21. Sign bor of Funeral Service License		St Have	en Cemet	ery [12 ess of Facility	2/18/04 Rest Haver	Harerstor	wn, Maryland				
<u>~</u>	permi Depar Impo any ir		12 h./	erstown Ma	aryland 21742									
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	Physician /Medical	Immediate Cause (Final disease or condition a. Lung Cancer resulting in death)												
	Examiner			Due to (or as a conse	quence of):									
	D ==	ner	Sequentially list conditions, I any leading to introduce cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):									
	ecuter and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):									
8760,	icate be executed physician and s the burial-transit	alE		Due to (01 as a conse	quence or).									
9	ate hy the	edic												
Вох	ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnanc	су		23d. Date o	,				
O. E	The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	Physiclan/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown	death 5	Other (specify)		THE STATE OF THE S	Month	Day Year				
S, D	s that med by e deta	by Ph	Part Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did t	obacco use contribu	te to the cause of death?				
ords	w require been sig should b	ted t	Taraneoplast	re Syndro	me			10	Yes 2□No 31	Probably 4 Unknown				
Record	e law r has be je 2 sh	Completed						24a. Was autor	osy prio	e autopsy findings available of to completion of cause of				
	icien: The certificate rector, pag	e Col	OS Man gang referred to medical					1 ☐ Yes		Yes 2□ No				
Viital	/siciel	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⚠ No	ospital: 1 Inpatient 2] ER/Outpatien	it 3 DOA Ot	har	of Death Check on a sing Home 5 - Resid		Speciful				
n of	Attending Physicien: r death. ector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of				how injury occurred	apacity)				
Siol	tendir leath. tor: Al	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1]Yes 2 □ No							
Division of	of or Attendent after deat Director:	Certification:	4 Homicide determined	28e. Place of Injury · At I building, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tov	Street and Number o vn, State)	or Rural Route Number,				
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Phys 2 Medical Examing	ician: To the best of my kn	owledge, death ation and/or in	n occurred at the t vestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)				
	To th within To th compl	Me	29b. Signature and title of certification	7		29c. Licen	se number	C = ~	29d. Date signed (M	fonth, Day, Year)				
						()	260	106 N	ecato,	16.2004				
5	٥؍٨		30. Name an dress of person who con	747 Morts	m 23a) (Type,	Print)	Hager	-stown	Maryla	r 16 2004				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	/				`				
	Registr	- 13	DEC 2 0 20	04 Deserve	M. Sy	restad.								

			For State Registrar	State o	of Marylan	d / Depa	artment of F	lealth and Death	Mental Hy	giene201 Reg. No.	04	41647
			1. Decedent's Name (First, Middle	, Last)					2. Date of De Month		Year	3. Time of Death
	Physicia /Medic		LASSIE		Uo.	35014			NEVEM	3 CR 22, 2	400	8:20P M
	Examin		4a. Facility Name (If not institution,	give street and nu	h .		4b. City, Town, o	_		4c. County o		
			11-11-10-10	DUENTES			I AK-GO		K.	More		
	Funeral			6. Sex 1 □ M 2\(\frac{1}{2}\)F	7. Age (In yrs.		If Under 1 Year Months Days	Hours M		y, Year) 9, 1928	9. Birthple Counti	ace (State or Foreign Y) 'H CAROLINA
	Director		239 58 0931 Usual Residence of Decedent		<u> </u>	76 Yrs.			JAN. 1	9, 1920	NOKI	.n CAROLINA
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	d. Inside City Limits
	Mary f sh	ğ	MARYLAND PRINC	E GEORGES	CAP	ITOL H	EIGHTS					XiX Yes 2 □ No
	1 the	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of W	hat Count	ry?
	death with the Maryland ms 23a or 28a-f show	Funeral Director	1122 CHAPELWOOD	LANE				20743		UNITE	D STA	TES
	ms 2	Jer	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No erto Rican, etc.)	14. Race	- America , White, e	
0	or Ite		1 Never Married 2 Marri	ed 1 Tes	orces?		1 □ Yes XX No	Specify:	0110 1 110411, 0101,		BLAC	
2007-	ours iral',	d by	3 Widowed 4 □ Divorced	Year or I	Dates:							
'n	within 72 hours after ene. then "naturel", or Ite ne Weolcal Extenire	Completed	15. Decedent (Specify only highes			(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v	vorking	16b. Kind of Bus	iness/Indu	ıstry
7	within	шb	Elementary/Secondary (0-12) 12TH	College	1-4or 5+)	me.	HOMEMAK!			OWN HO	ME	
И	filed y Hygie other ent, it		17. Father's Name (First, Middle, I	_ast)		1	HOPILITAN		lame (First, Middle,			
and	uld be filed within Mental Hygiene. rkad other then " tic event, the Westic	o Be	JOE L. LENNON					LIZZ	LE (UNKNO	WN)		
<u></u>	should Ind Men	To	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	er, City or Town, S	itate, Zip (Code)
Z	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. If the marked other then "natural", or items 23a or 28a-f show tiem 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Exeminal mast be notified at		JOHNNY DOBSON	/ SON		1122	CHAPELWO	OD LANE	CAPITO	L HEIGHT	S, MI	20743
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location - C	City or Tov	vn, State
Ē	Pages ent of nt: If i		¹XXBunal 2 ☐ Cremation ¹4 ☐ Donation 5 ☐ Other (S _t		State		L CEMETE		/29/2004	SUITLA	ND, M	Œ
aitimor	permit. Page Department of Important: If any injury or pnce.		21. Signature of Funeral Service I	icensee	٥	2	Name and Addre	ss of Facility	AL HOME O	F MARYLA	ND.IN	IC.
מ	80 5 8		MAM	mish	TPL		308 SUIT			TLAND, M		
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not en	er the mode of dxir	ng, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a.	(a	edia	e la	14360	te			Oriset and Death
	/Medical Examiner	5	resulting in death)	Due to	(or as a consec	uence of):		- 1	مام	1		
	LABITIME	7	Sequentially list conditions,	b. Due to	(or as a consec	MUO.	Clan	al 1	raem or	mage]		2 1
7	ped list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(0) 43 4 0011304	FC	10		0	a / \	NO	DMG
	certificate be executed ding physician and use as the burial-transit	xar	that initiated events resulting in death) Last	C. Due to	(or as a conseq	uence of):	10.	A i	((a. W	/	
2/PU	e be sicial	Ical		d		(100	eulon	altry	1/2	LA -		
g	g phy as th	9					1	1	ANI	104		
XO RO	h cert endin use	lan/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnation	ancy	Ectopic pregnanc	. \ \ .	0 12	23d. Date		
מ	death te atten ed for u	O	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)	X		Mon	ın ı	Day Year
r O	at the by the	Physi	9 Unknown						00- 014	<u>'</u>		
_	w requires that the death certificate been signed by the attending phys should be detached for use as the	by	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contri Yes 2 1010 :		bly 4 Unknown
ecords,	requir	Completed	- Dave		1000	au			-			
ပို	has b	nple	- That	Dlay	-10	na	I all	Dan	24a. Was	osy pr	ere autop for to com eath?	sy findings available pletion of cause of
=	: The I	Co	- The	1/hm	re				1 ☐ Yes	2 2 No 1	Yes 2	2□ No
VItal	ysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			_ Ott	ar.	Death (Check only o			
0		. To	1 Yes 2 No 27. Manner of Death	1		ER/Outpatier	IL 3 DOA	4 LI NUI SING	Home 5 Resident	dence 6 Other		
	Attending Physician: ar death. rector: After this certific by the funeral director.	tlon	1 Natural 5 Pendin	3	of Injury oth, Day Year)	Injury 7:00	Wor	Yes 2 No	FELLERO		_	
DIVISION	Attendir death. ctor: Al y the fu	fica	3 Suicide 6 Could				eet, factory, office	•	28f. Location (Street and Numbe	r or Rural	Route Number,
\leq	after after Dire	Certification:	4 Homicide		ting, etc. (Special Cost of Co					m, State) 76.6		RCCL AVE.
	Hospital 4 hours a Funeral I tely filled			g Physician: To th	e best of my kno	owledge, deat			ice, and due to the	cause(s) and man	ner as sta	led.
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	edical	one)	and ma	nner stated.	ation and/or in	?		ccurred at the time,			
	To the within 2 To the complet	Σ	29b. Signature and title of certified				29c. Licens	nedmun ea		29d. Date signed	(Month, D	ay, Year)
							5	614	/	[2]	6/	04.
)	(6)		30. Name and address of person	who completed cau	use of death (Iter			RROLL A	VE TIME	DIVIA PARI	1	20912
	0		31. Date filed (Month, Day, Year)	60,141.8	Registrar's Signa		1610 CAI	men R	VO. CPIC	OING TAKE	-, 171	DVIIC
	Sta Registr			004	N. 4	e has	200					

			1 - For State Registrar	State of Marylar		rtificate of		/Iental Hygi Re	g. No.20	04	41648
Г	Physici		1. Decedent's Name (First, Middle, Last) Lorraine Finch Dud	_				Decembe:		Ŏ Ŏ 4	3. Time of Death 7:45 p.m.
	/Medic Examir		4a. Facility Name (If not institution, give the street)	street and number)		4b. City, Town, or Indian	r Location of Death		4c. County		
*	Funeral Director		5. Social Security Number 6. Security Number 1 577-40-4041	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 15	, 1924	9. Birthpl Coun Lond	ace (State or Foreign try) on, England
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Charles 10e. Street and Number		ty, Town or Lo			10	g. Citizen of W		0d. Inside City Limits 1X1 Yes 2 □ No
	3c or	i Dir	#2 First Street,			20640			U.S.A.		uy:
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or itams 23c or 28a-f show or other traumatic event, the Medical Exertil at the Incilling at	by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Oecedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	Black	Americ k, White, c	etc.
15-0	in 72 ho "natu	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	eation during most of work d)	king	6b. Kind of Bu	siness/Inc	lustry
212	a filed within al Hygiene. I other than " vent, the Me	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Bar T	ender!		1	J.S. Go	vern	ment
Maryland 21215-0036	should be filed nd Mental Hygi i marked other umatic event, II	To Be (17. Father's Name (First, Middle, Last) Harry Finch				Sophia		Jnknown	<u> </u>	
Mar	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Ty				and Number or Rui				
	ages 1 and 2 nt of Health I: If item 27 i		Tina Peck 20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ F	lemoval from State	Place of Dispo cemetery, crei	osition (Name of matory or other place	Ave., Fa Dec. 16 ral Servi	Date 2	0c. Location - (City or To	wn, State
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice		22	2. Name and Addre				•	Virginia
The State of	Prrysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complishock, of hear failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events	Due to (or as a consector)	th. Do not ent		ng, such as cardiac				Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.	quence of):						
.O. Box	that the death certifica ed by the attending phi detached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3]Ectopic pregnancy] Other (specify)	′		23d. Date Mon	of delive	ry Day Year
Δ.	sign d ba	by	Part II. Dther significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did toba			e cause of death?
al Records,		Completed						24a. Was and autopsy perform 1 Yes 2	ed? de	Vere autoprior to comeath?	osy findings available inpletion of cause of
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	05	th (Check only one one 5 Presider		r (Specify)
ion of	Jing After funa	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor	y at	28d. Describe how			
Division	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, str fy)	reet, factory, office		28f. Location (Str. City or Town,		r or Rural	Route Number,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in I	edicai	29a. Certifier 1 Certifying Physical Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	пе, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and mar e and place, a	nner as stand due to	ated. the cause(s)
	To the within 2 To the complete	Z	29b. Signature and title of certifier Museum 12	ulb		29c. Licens		29	d. Date signed	(Month, E	Oay, Year)
5	3612		30. Name and address of person who co	therwood 1	2070	Print) Old Un	5414 Center	Wald	014,0	no	DORODY
No. of Lot	Sta Regist		31. Date filed (Month, Day, Year) DEC 1 6 2	32. Registrar's Sign	ature	barle					

	1.	For State Registrar	State of I		-					ental Hy	giene Reg. No.	_	4 4161
Physician /Medical Examiner		Decedent's Name (First, Middle Ann Louise Du Facility Name (If not institution	ıffy	er)		4b. City,	Town, or	Location of		2. Date of Dea Month December	er 1	Year 3, 200 County of De	4 1:51 E
Funeral Director	5. 38	Anne Arundel M Social Security Number 37-20-3887		ter Age (In yrs. Ia 84	ast birthday) Yrs.	If Under Months	1 Year	napol If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da April	y, Year)	9. B	Arundel irthplace (State or Fore Country) isconsin
Ba-f show	10	2	Arundel	10c. City	, Town or Lo			apoli	is				10d. Inside City Lim
hin 72 hours after death with the Maryland an "natural", or Itanis 23a or 28a-f show Medical Examinar must be notified at an or the transmission of the procession of the proc	10 10 11	17 King Court Marital Status	12. Was Decede	ent Ever in U.S	S. 13. \	10f. Zip		214		cify Yes or No- Rican, etc.)		U.S 14. Race - Arr Black, Wh	• A •
d within 72 hours after gjene. It the Medical Examina	2	1 Never Married 2XXMarr 3 Widowed 4 Divorced	ied 1 □ Yes 2 If Yes, Give Year or Date	⊠ No		I□Yes :	≥ X No	Specify:				Specify:	White
led will lygien har tha	17	(Specify only highes Elementary/Secondary (0-12) 7. Father's Name (First, Middle,	College (1-4 5+	or 5+)	16a. Deced (Give life. L	Teach				(First, Middle,	Maiden	Educa	tion
ld be ental ked c	2	Francis Ryan I	ouffy			-		Lou	uise or or Ruma	Haydon	Duf	fy r Town, State,	
permit. Pages 1 and 2 shou Department of Health and M Important: If itam 27 is man any injury or other traumatt page.	20	Kevin Duffy/so a. Method of Disposition 1XXBurial 2 □ Cremation 4 □ Donation 5 □ Other (S)	3 □Removal from Sta	ale	ace of Dispo emetery, cren Anne	sition (Nan natory or o	ne of ther place	9)	D	apolis, ate 7/2004	20c. Lo	cation - City o	21401 or Town, State , Maryland
permit. Pages Department of 8 Important: If its any injury or of		1. Signature of Funeral Service	loan		14	. Name an	d Addres	s of Facility	yJohn ucest	M. Tay	ylor An	Funera	al Home s, MD 21401
Physician /Medical Examiner	lr d	3a. Part1. Enter the disase, or shock, or heart failure. List mmediate Cause (Final isease or condition asulting in death)	Due to (of Seps	as a consequ	ence of):	ear	- /	fo	Jur	2C			Interval Between Onset and Death 5 days
eath certificate be executed attending physician and for use as the burial-transit	ĭ re	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events ssulting in death) Last	c. Page	as a consequal as a consequal	Ý								2 days
0 0 O	I A SICIOI NAME OF THE PROPERTY OF THE PROPERT	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		n 2 ☐ Fetal t at time of de	death 3	Ectopic pr					2	23d. Date of d	elivery Day Year
es the igner	֓֞֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֟֓֓֓֓֓֓֟֓֓֓֓֟֓֓֓֓	art II. Other significant condition	ons contributing to deat	h but not resu	Iting in the u	nderlying c	ause give	n in Part I.			es 2		to the cause of death? Probably 4 □Unknov
40 07		5. Was case referred to medical						26 Blace	of Death	24a. Was autop perfor 1 Yes	sy med? 2 No	prior to death?	autopsy findings available completion of cause o
ing Phys Miter this uneral di	2	examiner? 1 Yes 2 Too 7. Manner Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 Dmp 28a. Date of (Month,	1	ER/Outpatien 28b. Time of Injury		8c. Injury Work	or: 4 □ Nu at	rsing Hom	ne 5 Resid	lence 6		ecify)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Madical Certification:		3 ☐ Suicide 6 ☐ Could determ	ined 28e. Place or building	Injury - At ho	')			o deta		City or Tow	m, State)		Rural Route Number,
To the Hosp within 24 hou To the Fune completely fil	2	9a. Certifier (Check only one) 9b. Signature and title of certifie	g Physician: To the be Examiner: On the basi and manner	s of examinat	wiedge, death	vestigation,	in my op	number	th occurre	ed at the time, o	date and	place, and du	as stated. ue to the cause(s) oth, Day, Year)
	30	D. Name and address of person	who completed cause	of death (Item	23a) (Type, 888	Print)	den	112	91	#Z15	De	c.14	, 2004 s, Md
State Registra	#	1. Date filed (Month, Day, Year)		istrar's Signat		book	> 'y "	1	NC1	, ,	/ [*]	- Inform	7, 12

Registrar DHMH 17 Rev 1/2001

			. 101	epartment of Health and Mental Hygiene Certificate of Death Reg. No. 004 4 650
	46,		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medio		James Milton Emerson	December 19 2004 7:15P M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
			12830 Cathedral Ave	Hagerstown Washington County Hunder 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthbleson (State or Foreign)
	Funeral Director		5. Social Security Number 227–10–9729 6. Sex 1 M 2 □ F 7. Age (In yrs. last birtho	Months Days Hours Min (Month Day Year)
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location 10d. Inside City Limits
	Mary -1 sh	to	Maryland Washington Hage	rstown 1 □ Yes 2 💆 No
	h the	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	th wit	alD	12830 Cathedral Ave	21742 U.S.A.
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Agned Forces? 11 /16 /1	13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, 15. Was Decedent of Hispanic Origin? (Specify Yes or No- 16. Black, White, etc.
36	s afte		If Yes, Give 1/15.19	461 Yes 2X No Specify: White
8	hour	ed b		ecedent's Usual Occupation 16b. Kind of Business/Industry
15	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-1 show he Madical Examiner must be notified at	plet	(Specify only highest grade completed)	live kind of work done during most of working fe. DO NOT use retired)
21215-0036	filed with Hygiene. other ther snt, I're N	Completed by		ine Superintendent Power Company
nd	be filed tal Hygi d other avent, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Z	should be and Mental amarked o umatic ave	2	Milton Emerson	Elmer Wood
Maryland	0 0 00		G 3 77 79	lailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Cathedral Ave. Hagerstown Maryland 21742
	ss 1 and of Health itam 27 other tr			Sposition (Name of crematory or other place) Date 20c. Location - City or Town, State
Ö			ZZE Bunar 2 Cremation 3 Chemoval noin State	Chapel Cemet 12-22-04 Luray Virginia
Baltimore,	in in the street		21. Signature of Fu, eral Service Licensee,	22. Name and Address of Facility Douglas A. Fiery Funeral Home
ä	Depril Impo			1331 Eastern Blvd. N. Hagerstown Maryland 21742
ı,			23a. Part1. Entek the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
4	Priysician		Immediate Cause (Final disease or condition resulting in death)	PORO CEREBRAL DISEASE GENE
	/Medical Examiner		Due to (or as a consequence of)	20170 CEREBRAL DISZASZ YEAR
	15.55	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	COTTO (FIGDICA) DISTASE GENE
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
o,	an an rial-tr	Еха	resulting in death) Last C. Due to (or as a consequence of):	
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	llcal	d	
9	eath certifica attending ph for use as t	ĕ	IF FEMALE:	
Вох	attend for us	lan	In the past 12 months?	3 ☐ Ectopic pregnancy 23d. Date of delivery 5 ☐ Other (specify) Month Day Year
o.	at the de by the a stached	Physiclan/M	1 Yes 2 No 9 Unknown	3 United (Spaciny)
٥,	res that igned b be deta	by PI	Part II. Other significant conditions contributing to death but not resulting by the	
ords	w require been sig should b		CHICOTAC DACENWAR	EL INECIION 1 Yes 2000 3 Probably 4 Unknown
\approx	5 8 4 E			<u> </u>
e	law nas b	nplet		24a. Was an autopsy findings available prior to completion of cause of
al Rec	The ate h page	Completed		24a. Was an 24b. Were autopsy findings available
Vital Rec	The ate h page	Be	25. Was case referred to edical examiner?	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 Yes 2 No 1 No
of Vital Records,	Physician: The this certificate h ral director, page	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner Teath 28a. Date of Injury 28b. Tim	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 N
of	iling Physician: The h. Affer this certificate h funeral director, page	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 26. Place of Death Check on a cutient 3 DOA Cther: 4 Nursing Home 5 residence 6 Other (Specify) e of 28c. Injury at 28d. Describe how injury occurred
of	death. ctor: After this certificate h y the funeral director, page	To Be	examiner? 1 Yes 2 No 27. Manner eath 1 trural 5 Pending investigation 3 Suicide 6 Could not be determined	24a. Was an autopsy findings available prior to completion of cause of death? 26. Place of Death Check on a completion of cause of death? 26. Place of Death Check on a completion of cause of death? 27. Therefore the completion of cause of death? 28. Location (Street and Number or Rural Route Number, completion of cause of death? 29. No 26. Place of Death Check on a completion of cause of death? 27. Therefore the completion of cause of death? 28. Location (Street and Number or Rural Route Number, completion of cause of death? 29. No 29. No 20. No 20. No 20. Place of Death Check on a completion of cause of death? 29. No 29. N
	death. ctor: After this certificate h y the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner eath 1 I trual 28a. Date of Injury (Month, Day Year) 28b. Tim (Month, Day Year) 28b. Tim (Month, Day Year) 28b. Tim 28c. Place of Injury - At home, farm, building, etc. (Specify)	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No No No No No No No
of	death. ctor: After this certificate h y the funeral director, page	Certification: To Be	examiner? 1 Yes 2 No 27. Manner eath 1 tural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) 29a. Certifier Medical Examiner: On the basis of examination and/or minus to the basis of examination	24a. Was an autopsy findings available prior to completion of cause of death? 26. Place of Death Check on a completion of cause of death? 26. Place of Death Check on a completion of cause of death? 27. Therefore the completion of cause of death? 28. Location (Street and Number or Rural Route Number, completion of cause of death? 29. No 26. Place of Death Check on a completion of cause of death? 27. Therefore the completion of cause of death? 28. Location (Street and Number or Rural Route Number, completion of cause of death? 29. No 29. No 20. No 20. No 20. Place of Death Check on a completion of cause of death? 29. No 29. N
of	death. ctor: After this certificate h y the funeral director, page	To Be	examiner? 1 Yes 2 No 27. Manner eath 1 tural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify) 29a. Certifier Medical Examiner: On the basis of examination and/or minus to the basis of examination	24a. Was an autopsy performed? 1
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate h completely filled in by the funeral director, page	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner eath 1 tural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 6 Westing Physician: To the best of my knowledge, declared (Check only one) 28a. Date of Injury 28b. Time (Month, Day Year) 28c. Place of Injury - At home, farm, building, etc. (Specify)	24a. Was an autopsy performed? 1
Division of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate h completely filled in by the funeral director, page	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner eath 1 tural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 6 Westing Physician: To the best of my knowledge, declared (Check only one) 28a. Date of Injury 28b. Time (Month, Day Year) 28c. Place of Injury - At home, farm, building, etc. (Specify)	24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death Check on a Cther: 4 Nursing Home 5 Hesidence 6 Other (Specify) e of Yor Town, State) 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
Division of	death. ctor: After this certificate h y the funeral director, page	Medical Certification: To Be	examiner? 1	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 26. Place of Death Check on a control of the course of death? 27. Cther: 4 Nursing Home State of the course of death? 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dec. 12:40 A M 2004 William Elliott 11 Charles /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chestertown Chester River <u> Hospital</u> Center If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F Months Davs Hours Director 220-26-3026 74 April 19,1930 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-1 show d other than "natural", or Itams 23a or 28a-1 shovevent, the Modical Exeminer must be notified at 1 Yes 2 No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 413 Calvert Street 21620 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritat Status Rtack White, etc. fited within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates: Specify: Black. à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) of Health and Mental Hygiene. College (1-4or 5+) Dixon Valve 6 Co. Packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Clark ٥ Reba Elliott George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Morris Blake / Nephew 9049 Georgetown Rd., Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State Bordley Cemetery 12-18-2004 Pondtown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Sign ur Funeral Service Licensee 22. Name and Address of Facility
Bennie Smith Funeral Home
Road 298, Chestertown, Maryland 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) SHOCK SHOTIC **Physician** /Medical Examiner 15 clternic 13000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last Lue to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) burialphysician Box 68760 Physiclan/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 No 2⊟ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat. Certification: To 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Mannel Death 28c, Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation atural death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature nd title of certife 10060301 mpleted cause of death (Item 23a) (Type, Print).

A MD 1245 (FEM PS) STES CHESTER TOWN, MS HOMON MICERAST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of M	laryland / De		nt of H	ealth a			jiene	200	4_1.1650
	Dhusisi		1. Decedent's Name (First, Middle	, Last)					2	. Date of Dea Month	th Day	Yea	3. Time of Sealth
	Physici /Medic Examin	al	Robert Edmund 4a. Facility Name (If not institution)	4b. Cit	y, Town, or	Location of		ecember	9, 20	004 ounty of De	8:10p M
			Shady_Grove Ad	ventist Hos	pital	Re	ckvil	lle			Mor	tgome	ery
	Funeral		5. Social Security Number		ge (In yrs. last birtho	Month	er 1 Year S Days	If Under 2 Hours	Min. 8	. Date of Birth (Month, Day	Year)	9. B	lirthplace (State or Foreign Country)
	Director		033 20 1358	12.111 2	75 Yrs	5.			A	pril 8	, 192	29 Ma	ssachusetts
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location							10d. Inside City Limits
	the Marylar 28e-f show	ō	Maryland Montq	omery	Rockvil	le							1 ☐ Yes 2 ☐ No
	with the Maryland a or 28e-f show	Director	10e. Street and Number			10f. 2	ip Code				0g. Citize	on of What (Country?
	ours after death with the Maryla ral', or Itams 23a or 28e-f shov Examinar must be nutified at	0	14407 Barkwood	Drive			20853	3			USA	A	
	ier death itams 23 ner must	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Dec	edent of Hi	spanic Orig	gin? (Speci	fy Yes or No-	14	Race - An Black, Wi	nerican Indian,
98	or its		1 Never Married 2 Marri				2 🔯 No		, , aono m	outt, oto.,	.5	Specify:	White
9		d by	3 Widowed 4 Divorced	Korean	1								
21215-0036	"net	Completed	15. Decedent (Specify only highes	's Education it grade completed)	(0	ecedent's Us Give kind of the fe. DO NOT	vork done o	luring most	of working		16b. Kind	d of Busines	ss/Industry
12	within ene. than "	m d	Elementary/Secondary (0-12)	College (1-4or	5+)		236 / 01// 00/	,			Centra	l Inte	lligence Agency
d 2	e filed withir Il Hygiene. other than		17. Father's Name (First, Middle,	<u> </u>	Alla	lyst		18. Mother	r's Name (First, Middle,			
an	Mental Mental rked c	To Be	Gerald Ellswor	th Eisenhau	r			Mary	y Ron	avne			
Maryland	2 should be and Mental is marked a	-	19a. Informant's Name/Relationsh			lailing Addre	ss (Street a			Route Number	r, City or	Town, State	, Zip Code)
	5 를 2 로		Elizabeth M. E	: :isenhaur/Wi	fe 144	07 Ba:	rkwood	d Driv	ve, R	ockvil:	le, N	Maryla	and 20853
Je,	itam itam		20a. Method of Disposition		20b. Place of D		ame of		Dail December	е			or Town, State
E	mit. Pages partment of hoportant: If its y injury or of		1 ☐ Burial 2 反 Cremation 1 ☐ Donation 5 ☐ Other (Si		Metropoli	itan Ćr	ematory	, D	2004		lexar	dria,	Virginia
Baltimore,	permit. Departn Imports any inju		21. Signate of Funeral Service	Licensee		22. Name	and Addres	s of Facility	Fire	al Home,			
<u>m</u>	Dep imp any any		Cinchen) Check	2								Maryland 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	com lica ions that cause only ne ause on each	ed the death. Do not line.	enter the m	ode of dying	g, such as o	cardiac or i	espiratory arr	est,	1 5.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	J	4 CUTE	LE	VKE	Mi	A				Onset and Death 3 MWNTH (
1	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of)								
	LAGITITIE	_	Sequentially list conditions,	b. Due to /es a	s a consequence of).								<u> </u>
	pet Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a.	s a consequence or).								
	ate be executed hysician and the burial-transit	хаг	that initiated events resulting in death) Last	c Due to (or a	s a consequence of)	:					-		
760,	sician buris	calE											
687	ficate physis the												
Вох	death certificat e attending phy ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		-0-					23	d. Date of d	lelivery
ğ.	death e atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a	2 ☐ Fetal death at time of death	3 ☐ Ectopic 5 ☐ Other (Month	Day Year
P.0	that the der	hys	9 Unknown	9□ Unknown									
	requires that the een signed by th nould be detache	by F	Part II. Other significant condition	ns contributing to death	but not resulting in th	ne underlying	cause give	n in Part I.					to the cause of death?
ord	w requir been si should		-	-						1 🗆 Ye	es 2 📶	No 3 □ I	Probably 4 Unknown
ecc	aw is b	Completed								24a. Was a	y	prior to	autopsy findings available completion of cause of
H	ate pag	Con								perform 1 ☐ Yes	ned? 2 12 No	death?	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11			100			Check only on			
) t	Physi this c	ပို	1 Yes 2 No	Hospital: 1 Ampat			OOA Othe	4 Nur		5 Reside			pecify)
n c	ding F h. After funera	lon:	27. Manner of Death 1 ➡Natural 5 ☐ Pendin		ury 28b. Tim ay Year) Inju		28c. Injury Work	at :? /es 2 □ N		d. Describe ho	ow injury (occurred	
isio	Attanding or death. ector: After by the fune	icat	2 Accident investig	not be	njury - At home, farm					f Location (SI	reet and	Number or I	Rural Route Number,
Division of Vital Records,	lor A after Direction by	Certification:	4 Homicide determ	building, e	tc. (Specify)	, 311001, 1401	ory, onice		-	City or Town	n, State)	<i>vombor or r</i>	larar ricolo reamber,
_	Hospital		29a. Certifier 1 Certifyin	g Physician: To the bes	t of my knowledge, o	leath occurre	ed at the tim	e. date and	d place, and	d due to the ca	ause(s) at	nd manner a	as stated.
	e Ho: 24 h e Fur letely	edical	(Check only 2 Medical I	Examiner: On the basis and manner s	of examination and/o	or investigation	on, in my op	inion, deat	h occurred	at the time, d	ate and p	lace, and du	ue to the cause(s)
	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the	Me	29b. Signature and title of certifier				9c. License			2	9d. Date	signed (Mo	nth, Day, Year)
	12/		Velou de	160			0516	16			12 -	10-	2004
	10		30. Name and address of person	who completed cause of	death (Item 23a) (Ty	pe, Print)							
			Nelson Kalil	18111 Prince	e Philip &	V2#	3270	lue4	MI	MUND	ونه	832	
	Sta		31. Date filed (Month, Day, Year) DEC 13		trar's Signature		Es Also d						
	Registi	ar	DEO TO	LUU4 LUU4	63	Carl Carl	The All ra of	F					

FOULK

JEAN

Physicia	_	State Registrar				rtificat			IIIG IVI	lental Hyg	Reg. No.	004		416	54
/Medica	in al -	Decedent's Name (First, Middle, Last Alberta A. Facility Name (If not institution, give)	Fendal1			4b. City,	Town, or	Location o	f Death	2. Date of Dea Month 12	07		ear)4 Death	3. Time	
Funeral Director		3//-36-63/3	x 7. A □M 2\\ F	ge (In yrs.	last birthday) Yrs.	Co If Under Months	1umb 1 Year Days	ia If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 06 05		oward 9.			or Forei
ne Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard			ity, Town or Lo	a							10)d. Inside (City Limi
us after death v	by Funeral	10e. Street and Number 5350 Brook Way # 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Striverced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? INo		Was Deced If Yes, spec	_044 dent of Hi cify Cubar 213 No	Specify:	in? (Spe Puerto f	icity Yes or No- Rican, etc.)	14	USA 4. Race - / Black, V	America Vhite, e	in Indian, itc.	
d within piene. r than "	To Be Completed	(Specify only highest grace Elementary/Secondary (0-12) 12th. 17. Father's Name (First, Middle, Last) Harvey D. Thoma	le completed) College (1-4or	5+)	(Give life.	kind of wo DO NOT us O Fil	rk done a se retired,	furing most 18. Mother		ng (First, Middle,	U.S	Gor Busine Gor Gumame)			
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If item 27 is marked othe any Injury or other treumatic event, once.		19a. Informant's Name/Relationship (T) Loretta R. Engram 20a. Method of Disposition 1 ဩBurial 2 □ Cremation 3 □ 6 1 □ Other (Specify, 21. Signature of Funeral Service Licens	ype, Print) A/Daughter Removal from State	20b.	5350 Place of Dispo cemetery, crer ct Linc	Broo sition (Nar matory or o	k Wa me of other place	y #2	Colu D 2-13	I Route Numbe imbia, M ate 3-04 cshall's	ID. 2 20c. Loca Brent	1044 ation - City	or Tov	vn, State	
Physician /Medical Examiner	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ilications that cause ne cause on each la. Lung Due to (or as Due to (or as Due to (or as	Canc s a consec s a consec	th. Do not ent er quence of):					Washing r respiratory arr		D.C.		011 Approxima Interval Be Onset and	etween
that the death certifics ad by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	Ectopic pr Other (sp					23	d. Date of Month		•	Year
es ti gne bed	à	Part II. Other significant conditions co	ntributing to death I	but not res	sulting in the u	nderlying c	ause give	n in Part I.		-	9\$ 2□	ontribut			
ate has	Be Completed	25. Was case referred to medical						26. Place	of Death	24a. Was a autops perform 1 Yes	med? 2 X No	24b. Were prior death	to com	sy findings pletion of o	availat cause c
After this funeral di	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	dospital: 1 lnpati 28a. Date of Inj (Month, Da	ury	ER/Outpatien 28b. Time of Injury		l8c. Injury Work	at	2	ne 5 ₩ Reside 8d. Describe he			Specify)		
	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of In building, e	tc. (Speci	fy) 			n date and	_	8f. Location (Si City or Town	n, State)				nber,
within 24 ho To the Fun completely	Medical	(Check only one) 2 Medical Exami	ner: On the basis of and manner st	of examina	ation and/or inv	estigation,	at the time, in my op	inion, death	pace, a	d at the time, d	ate and p	signed (Me	due to t	he cause(3)

December Shame (First, Meddes, Last) Sylvia Feldmann Feldmanner School Shame Sylvia Feldmann Feldmanner School Shame Sylvia Feldmanner Sylvia			1 - For State Registrar	State of Maryland	/ Departme	ent of Health and ate of Death	d Mental Hygie	200	1. 1.100
Sylvia Feldman Feldhammer As Feldhammer A	W. 1.7)	Ochine	ne or beam	2. Date of Death		3. Time of Death
Social Security Number C. Sax	/Medic	cal			4b. Ci	y, Town, or Location of De	December	9, 2004	1:30 A ^M
Use Secretary	Funeral	3	5. Social Security Number 6. Set	TM 21XTF	st birthday) If Uni Month	ler 1 Year If Under 24 F	in. (Month, Day, Y	9. Bird Go	hplace (State or Foreign untry)
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Marden Sumame)	D		Usual Residence of Decedent				Jul 25,	1912 New	YOTK 10d. Inside City Limits
The part of the	the Mary	ector		ch Bo		Zin Codo	100	Citizen of Mires Co	1 ☐ Yes 2 No
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Marden Sumame)	offer death with		Yarmouth E 2088	Armed Forces?	. 13. Was De	33434 edent of Hispanic Origin? pecify Cuban, Mexican, Pu	(Specify Yes or No-	JSA 14. Race - Ame	rican Indian,
Tr. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Marden Sumame) 19. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19. Date of Disposition (Name of Date	-UU3C	ed by		Year or Dates:	16a. Decedent's U	sual Occupation	16		
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Marden Sumame)	CLZT within 72 ane. than 'ne	mplet	(Specify only highest grad	e completed)	(Give kind of life. DO NO)	vork done during most of v use retired)	working		•
Physician / Medical Examiner 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Setw Onset and D weeks Physician / Medical Examiner Physician / Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Due to (or as a consequence of): D	land 2	Be		2	Secreta	18. Mother's N	lame (First, Middle, Mai		stem
Physician / Medical Examiner 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Setw Onset and Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Unter the death of the property of the set of the property of t	VICENTY 12 Shou h and M 7 Is mar		19a. Informant's Name/Relationship (T)		_	ss (Street and Number or	Rural Route Number, C		
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Physician / Medical Examiner Page 10 of the page 12 of the page 1	DAILIN Dermit. Pa Departmen Important any injury		the same of the sa	ле	22. Name	and Address of FacilityH	ines-Rinald:	i Funeral	Home
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			Immediate Cause (Final disease or condition	_	Do not enter the m	ode of dying, such as card	liac or respiratory arrest	LVCI BPII	Approximate Interval Between Onset and Death
Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease) Cause (Dis				Due to (or as a conseque	nce of):				
d	sxecuted n and al-transit	xaminer	Cause (Disease or injury that initiated events	c					
Second Processing Contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death but not resulting in the underlying cause given in Rari Other significant conditions contribution to death Other significant conditions contribute Other significant conditions contribution to death Other s	physicians the buri	cal	C.	d					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia 23e. Did tobacco use contribute to the cause of de 1	he death certif	yslclan/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 Ectopic				,
24a. Was an autopsy findings a autopsy performed? 1	US, T.	þ		ntributing to death but not resulti	ing in the underlying	cause given in Part I.			
= x = (U - x · · - x · · - x · ·	The taw rec	Complete					autopsy performed	prior to death?	completion of cause of
The state of the s	On Or Vite ling Physician h. After this certifi	To B	examiner? 1 Yes 2 No Pending	28a. Date of Injury 2	8b. Time of Injury	OOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Residence		Group Hom
28a. Date of Injury . At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number) 28d. Describe how injury occurred	JIVISIC	ertificat	3 ☐ Suicide 6 ☐ Could not be						ral Route Number,
29a. Certifier (Check only Check only 29a. Certifier (Check only 29a. Certi	e Hospita 24 hours e Funeral letely fillex		(Check only 2 Medical Exami	ner : On the basis of examination	edge, death occurre n and/or investigati	nd at the time, date and place, in my opinion, death oc	ice, and due to the caus courred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D-32332 December 10, 2004		Me	29b. Signature and title of certifier	42	2				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			· ·			#220 Cil	Corina M	20002	
State Registrar Suresh K. Gupta, M.D. 9801 Georgia Ave. #220 Silver Spring, MD 20902 31. Date filed (Month, Day, Year) DEC 13 2004 32. Degistrar's Signature			31. Date filed (Month, Day, Year)	32. Pegistrar's Signatur	ro # #		shring, MD	20902	

			1 - For Stata Registrer		State	of Maryla	nd / Dep <i>Ce</i>		of Hea	alth and					4	41656
Н	Physici	an	1. Decedent's Name (First, Min)						2	2. Date of Dea Month	th Day	Yea		. Time of Death
	/Medic	al	Gloria L. Fo					T				ec.	11,	2004		M q 00:0
	Examin	er	4a. Facility Name (If not institu	ion, give :	street and nu	imber)		4b. City, T	own, or Lo	ocation of De				County of De	ath	
	Europe		377 Grinstea 5. Social Security Number	d Roa		7. Age (In vrs	s. last birthday)	If Under 1	Year S	-Vern	Pa Irs. Pa	rk B. Date of Birtl (Month, Day		Anne	Aru	inde] (State or Foreign
	Funeral Director		133-20-7720		M 200 F	7						Month, Day		9. 8	Country)	NY
	ō		Usual Residence of Decedent								1	ici.	1 7 2	.0		
	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "natural", or Itams 23a or 28a-f show avant, the Medical Examinational Lemailled at	7	10a. State 10b. Cour		undel	10c. C	City, Town or Lo		rna F	Park						Inside City Limits
	the M	Funeral Director	10e. Street and Number													1 1 es 2 [A140
	with Sa or	اق	377 Grinste	ad Ro	naď.			10f. Zip (1.4.6			log. Citiz	en of What (
	Jeath	lera	11. Marital Status			edent Ever in	U.S. 13.	Was Decede	211 ent of Hispa		(Speci	ify Yes or No-	1	US 4. Race - An		ndian
9	or Ita		1 Never Married 2 N	arried	Armed Fo	2 No					ierto Ri	ify Yes or No- ican, etc.)		Black, Wh	ite, etc.	
21215-0036	ural',	d by	3 XWidowed 4 ☐ Divord	be	If Yes, Gi Year or E	Dates:		1 ☐ Yes 2	DAINO S	Specify:				Specify:	Whi	ite
<u>7</u>	"natu	lete	15. Deced (Specify only hig				(Give	dent's Usual kind of work	done durii	on ing most of	working	7	16b. Kin	d of Busines	s/Industr	у
12	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	netired) maker	_				Llomo		
9	filed Hygid Sther ant,		17. Father's Name (First, Midd	e, Last)				TIONG			Name (First, Middle,	Maiden S	Home		
an	lid be lental ked c	To Be	Leo Latzer									Bened		,		
Maryland	should and Mer s marke umatic	_	19a. Informant's Name/Relation				19b. Maili	ng Address (Route Number		Town, State,	Zip Cod	/e)
	and 2 paith a 127 is er tra		Judith F. Fl	etche	er/Daug					id Roa	d, \$	Severna	a Par	ck, MD	21	146
Baltimore,	ges 1 and 2 should it of Health and Mer it it itam 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crematic	3 □ B	emoval from	20b.	Place of Dispo cemetery, crei	sition (Name matory or oth	e of ner place)	ח	Dat	te 15		ation - City o		
Ĕ	Pages ment of ant: If it		`4 □Donation 5 □ Other			State	Metro (-			15 , 004		imore		
Salt	permit. Page Dependent Important: If any njury o		21. Signature of Funeral Servi	e License	7	//	- 22 F	Name and	Address o	Sons,	P. 7	A. Seve	erna	Park 1	Fune	ral Home
	40380		220 Davis Emanhadian	0	1 fr								31112	Park,	MILL	21.146
	_		23a Part1 Enter no disease, shock, or neaft failure. L Immediate Cause (Final	st only or			atri. Do not eni	er ine mode	or aying, s	such as card	lac or r	respiratory arr	est,		Inte	roximate rval Between set and Death
	Pnysician /Medical		disease or condition resulting in death)	_ a		etasta		Cance	er	to 1	IVE	V			10	days
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8760,	cate be executed physician and s the burial-transit	lical		d												
9	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE:	0	20 If you are	-							\top		1	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	2.	1 🗀 Live t	tcome of pregrointh 2 Fet nant at time of	al death 3□	Ectopic pred					23	ld. Date of de Month	elivery Day	Year
P.O.	the de	ysic	1 □ Yes 2 No 9 □ Unknown		9□ Unkn		dealli 5	Other (spec	ciry)							
	law requires that the deas been signed by the a	by Ph	Part II. Other significant cond	tions con	tributing to d	eath but not re	sulting in the u	nderlying cau	ise given in	n Part I.		23e. Did to	acco us	e contribute i	to the cau	use of death?
Records,	w requires been sign should be										_	1 X Ye	s 2 🗆	No 3∏P	robably	4 Unknown
000	aw re	Completed										24a. Was a				indings available
_	The ate h page	Com									_	autops perform 1 Tyes 2	ned?	death?	completi s 2 🗆 l	ion of cause of
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medi examiner?	al					26	6. Place of D	eath (Check only on				
of V	E E =	2	1 ☐ Yes 2 No	Н			ER/Outpatien		Other:	4 🗌 Nursing	Home	5 Reside	nce 6	Other (Spe	ecify)	
o uo	ing I	ion:	27. Manner of Death 1 Natural 5 □ Pen		28a. Date (Mon.	of Injury th, Day Year)	28b. Time of Injury		Work?		280	d. Describe ho	w injury	occurred		
isio	ttand death stor: / the f	icat	3 ☐ Suicide 6 ☐ Cou		290 Place	of Injune As 6		M		2 🗆 No	006	/04		** '		
Division	after Dirac	Certification:	4 Homicide dete	mined	buildi	ng, etc. (Speci	nome, farm, str ify)	eet, tactory, o	OTTICE		281	Location (St. City or Town	, State)	Number or H	<i>lurai H</i> ou	ite Number,
_	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certif	ing Phys	icien: To the	best of my kn	owledge, death	occurred at	the time. d	date and pla	ce and	d due to the ca	use(s) a	nd manner a	s stated	1
	na Ho n 24 h na Fu oletely	Medical	(Check only 2 Medic one)	il Examin	ier: On the b	asis of examin- ner stated.	ation and/or inv	estigation, ir	n my opinio	on, death oc	curred	at the time, da	ate and p	lace, and du	e to the o	cause(s)
	To tha within 2 To tha complet	M	29b. Signature and title of certi	ier					License nu			25	d. Date	signed (Mon	th, Day,	Year)
			fline	(A	R-	-		D	258	830		1)ec	Pinber	113.	2004
			30. Name and address of person			se of death (Ite	m 23a) (Type,	Print)	. 10					uper		
				Mer		Bes	tgate	Kind	(#5	07/	411	rapolis	1	102	140	0/
	Sta Registra	te ar	31. Date filed (Month, Day, Yea DEC 1	5 200)4 32	egistrar's Sign	ature	and a								,
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			Pleas	se Type or Prir	nt in Black I	ndelible ink. En	sure All Copies	Are Legible).
			for State	State of Ma		partment of Healtlertificate of Dea	th	2001.	1.1657
			1. Decedent's Name (First, Middle	, Last)		ertificate of Dea	2. Date of De		3. Time of Death
	Physici /Medio		HOWARD McKINLEY	GILBERT, J	R.		Decen	ber 8, 20	
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location		4c. County of D	* -
			DOCTOR'S COMMUN			LANHAM			E GEORGES
Ē	Funeral Director		5. Social Security Number 214 28 9901 Usual Residence of Decedent	6. Sex 7. Age 1000 7. Age	9 (In yrs. last birthda 72 Yrs.	y) If Under 1 Year If Unit Months Days Hour	der 24 Hrs. rs Min. AUG • 0.	y, Year)	Birthplace (State or Foreign Country) ASHINGTON, DC
	yland IOW		10a. State 10b. County		10c. City, Town or	Location			10d. Inside City Limits
	death with the Maryland me 23a or 28a-f ehow Li. wat be notified at	ctor	MARYLAND PRINCE	E GEORGES	UPPER M	ARLBORO			1 ☐ Yes 🗶 №
	or 28	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What	Country?
	ath w		10902 MOUNT LUBI			20774		UNITED S	
0030	d within 72 hours after dea giene. ir than "natural", or itame the Medical Excultrer to	by Funeral	11. Marital Status 1 □ Nøver Married ¾◯X Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2XX If Yes, Give Year or Dates:		 Was Decedent of Hispanic If Yes, specify Cuban, Mexit 1 ☐ Yes 2√√√No Specify 	,	14. Race - A Black, W Specify:	
3	2 hou		15. Decedent	s Education	16a. De	cedent's Usual Occupation		16b. Kind of Busine	ss/Industry
2	within 72 ene. than "na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5	life	ve kind of work done during n . DO NOT use retired)	nost of working		
Z	e filed wi Il Hygien other th vent, Ibe	Con	11TH			TRUCK DRIVER			VATE
and	0 0 0 0	Be	17. Father's Name (First, Middle, L				other's Name (First, Middle,	,	
5	should band marked umatic e	٦°	HOWARD McKINLEY 19a. Informant's Name/Relationsh			iling Address (Street and Nur	ATHERINE JACK		Zin Codel
2	s 1 and 2 should Health and Mer item 27 ie marke other traumatic		MARY GILBERT, WI			2 MT. LUBENTI		MARLBORO,	
n G	is 1 au of Hea item othe		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City	
E	t. Pages tment of tant: if it		XXBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp			NATIONAL CEM	12/13/04	LAUREL,	MD
Dail	permit. Pag Department Important: any itriury once.		21. Sign ture of Funeral Service	icensee	2	22. Name and Address of Fa MARSHALL S FU 4308 SUITLAND	NERAL HOME OF	F MARYLAND	,INC.
Ť			23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardia		hmia			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):	7377-05			Soays
ì.		Jer	if any, leading to immediate cause. Enter Underlying	b Caron of Due to (or as a	co equence of):	Direaso			15 years
	ocuted nd transit	amin	Cause (Disease or injury that initiated events	a Hypert	ensive b	eart Discase			15 years
Ž,	exe	EX	resulting in death) Last	De (or as a	a consequence of):	***************************************			15 years
00/00	cate b	dica		d. Sleep	apriea				15/410
.O. DOX	The law requires that the death certificate be exe ste has been signed by the attending physician a cage 2 should be detached for use as the burial-i	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	B⊟Ectopic pregnancy G Other (specify)		23d. Date of o	delivery Day Year
ŗ	s that med b e deta	by Pi	Part II. Other significant condition	s contributing to death bu	it not resulting in the	underlying cause given in Pa	art I. 23e. Did to	bacco use contribute	to the cause of death?
colds,	aquire en sig ould b		Congestive He	uit Failure,	Renal Fa	ilure, chron	1□Y	es 2□No 3□	Probably 4 Dunknown
ב	The taw re te has be age 2 sho	Completed	_ 1			e colitis, An	perior	sy prior t med? death	
N II a	ian: irtifica ctor, p	BeC	25. Was case referred to medical examiner?	postphlebiti	(>yndino)	10 10 90 1 26. Pla	ace of Death (Check only or	2 √ No 1 □ Yo	as 2□No
> 5	hysic this ce il dire	ဥ	1 ☐ Yes 2 X No	Hospital: 1 X Inpatier		ent 3 DOA Other: 4	Nursing Home 5 - Resid	ence 6 Other (Sp	pecify)
	anding F sath. or: After t he funera	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	ation	y 28b. Time Yea <i>r)</i> Injury			ow injury occurred	
2 2	Hoepital or Attanding Physician: The lav 24 hours after death. Funaral Director: After this certificate has letely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farm, : . (Specify)	street, factory, office	28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,
	e Hoepi 24 hour se Funar	edical	29a. Certifier (Check only one) 1 Cartifying 2 Medical E	Physician: To the best o xaminar: On the basis of and manner stat	examination and/or	ath occurred at the time, date investigation, in my opinion, d	and place, and due to the c death occurred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)

To the Hoepi within 24 hou To the Funar completely fill

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D05424

29d. Date signed (Month, Day, Year) December 9, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State RegistraMEND#32sce#3	20erMOHD12/13	/04.FMJ.MCCel	rtificate of D	eaith and iv	ientai mygie _{Reg.}		
	Physici	an	1. Decedent's Name (First, Middle,	Last)	7011211120			2. Date of Death Month	Day 20 Quali	3. Time of Death
	/Medi		Esther Berger G					December	6, 2004	9:30 A
	Examir	ier	4a. Facility Name (If not institution, g	give street and number)	1	4b. City, Town, or I	ocation of Death		4c. County of Death	
			Andrus House 5. Social Security Number 6	. Sex 7. Ac	ge (In yrs. last birthday)	Bethesda If Under 1 Year	If Under 24 Hrs.		Montgomery	
	Funeral Director		090-18-6534 Usual Residence of Decedent	1 M 2 M F	97 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye) 06/23/19	9. Birth Cour 07 New	place (State or Foreign htry) York
	ow ow		10a. State 10b. County		10c. City, Town or Lo	cation			1	Od. Inside City Limits
	Man,	ţō	MD Montgo	mery	Bethesda					1 ☐ Yes 2 ☑ No
	th the	irec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?
	th wil	ai D	10910 01d George	town Road		20814			U.S.A.	
036	be filed within 72 hours after death with the Maryland hal Hygiene. od other then "naturel", or Iteme 23a or 28a-1 ehow event, Tre Medical Exertirer must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:	No 1	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🌠 No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	C 2 04	Completed	15. Decedent's (Specify only highest (Specify only highest (Specify only highest (Specify only (Spec	grade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ion ring most of worki	ng 16t	b. Kind of Business/In	dustry
212	should be filed within of Mental Hygiene. marked other then "	шo	Elementary/Secondary (0-12)	College (1-4or	5+)	swoman			hildren's	Clothing
9	e file al Hy t othe vent,	Bec	17. Father's Name (First, Middle, La	st)		1	8. Mother's Name	(First, Middle, Mai		J
<u>a</u>	Menta	10	Jacob Leblang				Jennifer	Fishman		
Maryland	12 should be fil h and Mental H 7 le marked ott traumatic even		19a. Informant's Name/Relationship		19b. Mailin	ng Address (Street an	d Number or Rura	I Route Number, C	ity or Town, State, Zip	Code)
	and lealth m 27 her tr		Irma B. Kahn, Da	ughter		and the second s			land 20854	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 le marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 1 ☐ Donation 5 ☐ Other (Special Content of the Content			sition (Name of natory or other place) In Cremat	1		entwood, M	
Balt	permit. Departi Import any inj		21. Signature of Fun-tra Service Ly		Simple Tr	ibute lle, Maryl	and 20852			
	- ·		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused to one cause on each li	the death. Do not ente					Approximate interval Between
ì.	Physician		Immediate Cause (Final disease or condition	SEPS						Onset and Death
Ŋ,	/Medical Examiner		resulting in death)	- u.	a consequence of):					
	Examiner	_	Sequentially list conditions,	b. Pre	umonia.					
	ed sit	nine	cause. Enter Underlying Cause (Disease or injury	Due to for as	a consedinence of.					
	axecui and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760	icate be executed physician and s the burial-transit			d						
68	tificating phy as the	Medicai		u						
P.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	nry Day Year
	that led by deta		Part II. Other significant conditions	contributing to death b	out not resulting in the un	nderlying cause given	in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
rds	n sign	d by	Dinbet	is mell.	tus, Hy	per tension	ىد	1 🗆 Yes	2 No 3 Prob	ably 4 Unknown
00	law requir as been si 2 should	ompieted				,		24a. Was an	24b. Were autor	osy findings available
Re	Ф с <u>о</u>	omp						autopsy performed	? prior to con death?	npletion of cause of
ta		Se C	25. Was case referred to medical				6. Place of Death	(Check only one)	No 1 ☐ Yes	2 E No
of Vital Records,	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatient				6 Other (Specify	•)
0	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	28c. Injury a Work?	t 2	8d. Describe how in		
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigate 3 Suicide 6 Could not	he		M 1 TYe	s 2 No			
Division	after d after d Direct d in by	ertification;	4 Homicide determine		ury - At home, farm, stre c. (Specify)	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	To the Mospitel or Attending Phwithin 24 hours after death. To the Funetel Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the best aminer: On the basis o and manner sta	of my knowledge, death f examination and/or inv ated.	occurred at the time, restigation, in my opin	date and place, a ion, death occurre	nd due to the cause od at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License r	umber	29d.	Date signed (Month, L	Day, Year)
			1/2/	In m		000	9317		12/9/04	
	3		30. Name and aderess of person to	completed cause of d	leath (Item 23a) (Type, F					
_			Kobert F	Byrne,	yo 2333	5 NASK	St An	Lington	VA.	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	leath (Item 23a) (Type, F	4 Sener	~ 5	Spork	21	

			1 - For State Registrar	State of M	/larylar		artment of rtificate o			Mental Hyg	iene g. No. 20	04	41659
	Physici /Medio		1. Decedent's Name (First, Middle, LAURENCE M. G	OODMAN						2. Date of Deat Month DECEMBE	Day	Year 004	3. Time of Death 12:02 A M
	Examir Funeral	er	4a. Fecility Name (If not institution, ANNAPOLITAN ASS 5. Social Security Number	ISTED LIVIN	NG Age (In yrs.	last birthday)	4b. City, Town ANNAP If Under 1 Yea	OLIS ar If Under	24 Hrs.	8. Date of Birth	4c. County ANNE	ARU 9. Birt	INDEL
	Director		215-34-3358 Usual Residence of Decedent 10a. State 10b. County	1∭M 2□F	68	Yrs.	Months Day	s Hours	Min.	JANUARY [»]	12,193	6 MÅ	RYLAND
	the Maryla 286-f show	ector	MARYLAND ANNE A	RUNDEL	100.01	ARNOL	.D						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eth with 23e or 1	Funeral Director	408 TEE COURT				10f. Zip Code	012			g. Citizen of \	What Co	untry?
9036	72 hours after deeth with the Maryland naturel', or Iteme 23e or 28e-f show dical Examinar nurst be rediffed at	by	11. Marital Status 1 □ Never Married 2\(\textbf{X}\)\textbf{Marrie} 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces d 1 Vives 2 [I Yes, Give Year or Dates	196	0-	Was Decedent of If Yes, specify Cu			ecify Yes or No- Rican, etc.)	14. Rac	k, White	ncan Indian, e, etc. TTE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 le marked other than "naturel", or Iteme 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be treditived at once.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4o	r 5+)	(Give	dent's Usual Occ kind of work don DO NOT use retii	e during mos	it of work	ing	6b. Kind of Bu	usiness/l	ndustry
Maryland	should be file nd Mental Hy marked oth imatic event	To Be (17. Father's Name (First, Middle, L ALFRED KYLE GOO	DDMAN		,		SA	RA P				
	es 1 and 2 sho of Health and f item 27 le m r other treum		19a. Informant's Name/Relationshi GLORIA J. GOODMA 20a. Method of Disposition	N/WIFE	20b. P	408 T		Γ, ARNO	OLD,	Al Route Number, MARYLAN Date 2	D 2101	. 2 City or 1	Town, State
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 VBurial 2 Cremation : 4 Donation 5 Other (Sp.		0	LINCOL	N CEMETI	ERY		13,2004 _{Bl} orge F.			
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):													Approximate Interval Between Onset and Death
. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d. 23c. If yes, outcom 1 Live birth	e of pregna 2 ∐ Fetal	incy	Ectopic pregnan	су			23d. Date Mor		very Day Year
ds, P.O	juires that the de n signed by the a lid be detached f	by	9 ☐ Unknown Part II. Other significant condition	9∐ Unknown s contributing to death	but not resu	ulting in the ur	ndertying cause g	iven in Part I.					the cause of death?
al Records,		Completed								24a. Was an autopsy perform	ed? d	Vere autorior to coeath?	opsy findings available ompletion of cause of
ivision of Vital	ttending Phyedeath.	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga investiga 3 Suicide 6 Could no determin	t be 28e. Place of Ir	ay Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	ther: 4 🗌 Nu ury at ork?] Yes 2 🗍 î	rsing Hon	(Check only one, ne 5 ☐ Residen 28d. Describe how 28f. Location (Stre	ce 6 the the	ed	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical Cert	29a. Certifier 1 Certifying	Physician: To the bestaminer: On the basis	t of my know	wledge death	occurred at the t	ime, date and	d place, a	City or Town,	se(s) and mar	nner as s	stated.
	To the I within 2: To the I complete	Med	29b. Signature and title of certifier	and manner's	tated.	70	29c. Licen	ise number			1. Date signed	(Month,	Day, Year)
			30. Name and address of person when the control of	4	death (Item	23a) (Type, F	Print\			, Crytin			
	Sta Registr		31. Date filed (Month, Day Year)	3 200 4 32. Rec	rar's Signat	ture	Society.			1			

			For State Registrar	State o	f Man	yland / Der <i>Ce</i>	oartme e <i>rtifica</i>	ent of H	lealth and Death	Mental Hy	/giene Reg. No.	2004	41661
	Physici	20	Decedent's Name (First, Midd	e, Last)						2. Date of D Month	eath Day	Yeer	3. Time of Death
	Physici: /Medic		KEVIN EMERSON I				45 63	- T	al casting of Dool			0, 2004 ounty of Deeth	
	Examin	er	4a. Fecility Name (If not institutio					ERLIN	r Location of Deat	ur.		RCESTER	
	Funeral		5. Social Security Number	6. Sex		In yrs. last birthda	(y) If Und	der 1 Year	If Under 24 Hrs				ptace (State or Foreign intry)
e.	Director		222-62-5241	1 X M 2□F	2	9 Yrs.	Month	ns Days	Hours Min.	7/22/1	975		WARE
	pur &		Usual Residence of Decedent 10a. State 10b. County		11	Oc. City, Town or	Location		-				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23a or 28e-f ehow event, I'm Medical Examera inter the routhed at	o	DELAWARE SUSSI		1	FRANKFOR							1 ☐ Yes 2 🔣 No
	or 28e-f	Funeral Director	10e. Street and Number				10f.	Zip Code			10g. Citize	on of What Cou	intry?
	h with		RT. 1 BOX 62E						19945		U.S.	Α.	
	er death w items 23s	ner	11. Marital Status	12. Was Dec	edent Eve	er in U.S.	. Was De	cedent of H pecify Cuba	lispanic Origin? (5 an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14	I. Race - Ameri Black, White	
36	s after	by Fu	1 Never Married 2 Mar 3 Widowed 4 Divorce	If Yes, Gi	ve			2 X No	Specify:			specify: BLA	ACK.
Ş	72 hours natural'	ed b		nt's Education	741 0 5.	16a. Dec	edent's U	sual Occup	ation		16b. Kind	d of Business/Ir	ndustry
215	nin 72	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) Cotlege (1-4or 5+)	(Gir	e kind of DO NO1	work done Tuse retired	during most of wo	orking			
213	e filed within al Hygiene. I other than vent, the Me	Com	12				DISA	BLED				ABLED	
Maryland 21215-0036	be filed within 72 hours after death with the Maryla ital Hygiene. In the Maryla of other than "natural", or items 23a or 28e-f ehovevent, I'm Medical Examerational to rediffice at	Be	17. Father's Name (First, Middle	Last)						me (First, Middle		umame)	
Za	2 should be f and Mental b is marked of raumatic ever	1 0	ERNEST M. HALL 19a. Informant's Name/Relation	thin (Type Print)		10h Ma	iling Addre	ass (Straat	and Number or R	G. SHOCK		Town State Zi	n Code)
Mai	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		THELMA G. HALL	MOI	HER		-	,	, FRANKF		1994	_	<i>y</i> 3033)
<u>စ</u> ်	s 1 an f Heal item 3	1. 34	20a. Method of Disposition	_	1	20b. Place of Dis	position (f	Name of	ce)	Date	20c. Loca	ation - City or T	own, State
9	Page:		1 Surial 2 □ Cremation 14 □ Donation 5 □ Other (State				CEM 12/2	23/04	FRANK	FORD, D	DΕ
Baltimore,	permit. Pages 1 and 2: Department of Health at Important: If item 27 is any injury or other trau		21. Signature of Funeral Service	Licensee					ss of Facility				
	80 = 9		Richard T.	Wate	one				NERAL HOL			, DE	A
			23a. Pert1. Enter the disease, o shock, or heart failure. Lis	t only one cause on	caused the each line.	e death. Do not e	nter the m	iode of dyin	ig, such as cardia	c or respiratory a	arrest,		Approximate Intervat Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	94-	SACH	5	1515	GASE			4	FEW HOURS
	Examiner			Due to	(or as a c	onsequence of):							
000	\$10 A.	ler	Sequentially list conditions, it any, leading to immediate	b. Oue to	(or as a c	ronsaquence of):							
133	outed nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c.									
p 20°	e exec ien ar urial-t	Ex	resulting in death) Last	Due to	(or as a c	consequence of):							
19 28 4007 8760	cate be executed physicien and the burial-transit	dlcal		d									
1 × 8	death certific e attending p ed for use as	/Me	IF FEMALE:	23c. If yes, ou	itcome of	pregnancy					23	ld. Date of deliv	ren/
16 5 8 B	atten for us	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	Fetal death	B □Ectopic	pregnancy (specify)			23	Month	Day Year
C 40.	D 0 0	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr	iown								
CO Di	requires that the leen signed by th hould be detache	by Physician/Me	Part II. Other significant condit	ons contributing to	leath but r	not resulting in the	underlyin	g cause giv	ren in Part I.	23e. Did	tobacco use	e contribute to t	the cause of death?
Do Ords	v require been sig should b									10	Yes 2	.No 3 ☐ Pro	bably 4 □Unknown
2	The law ri ite has be bage 2 shi	Completed								24a. Was	ppsy	prior to co	opsy findings available ompletion of cause of
= XX = B		Соп								1 Yes	ormed? 2 ⊠ -No	death? 1 🗌 Yes	2 □ No
Ye v	ician: certific ector.	Be	25. Was case referred to medical examiner?	Hospital:				Oth	AC.	ath (Check only			
- 750	Phys	- L	1 No 27. Manner of Death	10	Inpatient of Injury			28c. Injur	y at	Home 5 Res			(fy)
777	iding f th. : After funer	ıtlon	1 Natural 5 ☐ Pend	ng (Morigation	nth, Day Y	(e <i>ar</i>) Injun	M	Wor	rk? Yes 2 ∐No				
HALL 222 - Division	of or Attendia after death. I Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could	nined 200. Flat	e of Injury ling, etc. (- At home, farm,	street, fac	tory, office		28f. Location	(Street and awn, State)	Number or Rur	al Route Number,
Ö	tel or At is after o el Direc ed in by	Certification;	4 - Homicide	- Julio	iling, etc. (эрвану)				0, 0	, 0.0107		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	edical	(Check only 2 Medica	ng Physician: To th	pasis of ex	kamination and/or							
	thin 2 the omplet	Med	one) 29b. Signature and title of certifi		ner state	d.		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	F × F S		Day att.	C. Holew	mH.	m.S.		1	06241		12	- 21-0	54
			30. Name and address of person				e, Print)						4
			DOROTHY	C. Hos	ZINO	RT4, 14	1.D.	203	3 SNOW	STI SA	IOW 1	TILL, MI	12, 21863
	Sta Registi		31. Date filed (Month, Day, Year DEC 2	32.1	Registrar's	s Signature	doan	W					ID, 21863

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of N	narylanu i	-	artment of H <i>tificate of L</i>		, ,	JIENE eg. No.	
Ę	Physici	an	1. Decedent's Name (First, Midd	fle, Last)					2. Date of Deat Month		3. Tyme of Peater
	Physici /Medio		Mertie Re						December	17 2004	
	Examir	er	4a. Facility Name (If not institution	on, give street and number	r)		4b. City, Town, or	Location of Death	1	4c. County of De.	
			5. Social Security Number	n County Hos	pital ge (in yrs. last	hirthday)	Hagers	TOWN 24 Hrs.	O Data of Righ		ton County
	Funeral Director			1 M 2 M F	81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	irthplace (State or Foreign Country)
			233-34-3245 Usual Residence of Decedent						March I	5 1923 we:	st Virginia
	ryland how		10a. State 10b. Count	у	10c. City, To	own or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Wash	ington	Hage	rsto	wn				1 □ Yes XX No
	ith th	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	Country?
	ath w	- La	11403 Stonec				21742			U.S.A.	
21215-0036	s 1 and 2 should be filled within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other then "neturel", or items 23e or 28e-f show other treumetic event. The Medical Examiner must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ☑ Divorce	It Was Chie	s? DNo		Was Decedent of Hi f Yes, specify Cuba I□Yes 2█ No	spanic Origin? (S _I n, Mexican, Puert Specify:	pecify Yes or No- Pican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
5-0	72 h	Completed	15. Decede (Specify only highe	nt's Education est grade completed)	10	6a. Deced	lent's Usual Occupa kind of work done o OO NOT use retired,	ation furing most of work	king	16b. Kind of Busines	s/Industry
121	within ne.	mpl	Elementary/Secondary (0-12)	College (1-4o	r 5+))	1	Dougonal I	Don't donor
12	filed with Hygiene. other the		17. Father's Name (First, Middle	(ast)	1	ПО	memaker	19 Mother's Nem	ie (First, Middle, N	Personal F	Residence
Maryland	ould be i Mental I arked o	o Be	Moses Beeler	, 2201/					ie Baddy	•	
Z	2 should and Men is marke sumetic	10	19a. Informant's Name/Relation	ship (Type, Print)	1	9b. Mailin	g Address (Street a			City or Town, State.	Zin Code)
	nd 2 :		Charles A. He							Maryland	
Baltimore,	0 0		20a. Method of Disposition 1 🔀 urial 2 🗆 Cremation	3 □Removal from Stat	20b. Place ceme	of Dispos	sition (Name of natory or other place	9)	Date	20c. Location - City o	r Town, State
3altin	permit. Pag Department Importent: f eny injury o		` 4 ☐ Donation = 5 ☐ Other (3		0		. Name and Addres			Fiery Fur	
	rnysician /Medical Examiner	er	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, list in the cause. Enter Underlying Cause, Disease or injury	a. Response to (other b. Employed)	ed the death. Deline. Is a consequence of the second of t	o not ente	er the mode of dying	g, such as cardiac	or respiratory arre	ıst,	Approximate Interval Between Onset and Death 12 hours
68760,	rtificate be executed ng physician and as the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	is a consequenc	ce of):					
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2		Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
Records, P.	n requires that been signed I should be det	by	Part II. Other significant condition A Therescl	ions contributing to death							o the cause of death?
Vital Rec		e Completed	25. Was case referred to medical							prior to death?	utopsy findings available completion of cause of s 2 No
Ē	Physicien: this certific	o Be	examiner?	Hospital:	tient 2 EB/	Outpatient	3□ DQA Cthe		h Check onl one	nce 6 ⊡Other <i>(Spe</i>	
of	g Ph) er this	F (27. Manner of Death	28a. Date of In	jury 28t	. Time of	28c. Injury	at	28d. Describe hor		эсігу)
ion	Attending Fr death. ector: After by the funer.	atlo	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, D tigation	ay rear)	Injury	M 1 ☐ Y	? 'es 2 □No			
Division	of or Attendate death Director:	Certification	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	mined 289. Place of Ir	njury - At home, etc. <i>(Specify)</i>	farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R. , State)	ural Route Number,
	To the Hospitel or within 24 hours atter To the Funerel Director Completely filled in the Funerel Complet	edical C	29a. Certifier (Check only one) 1 Certifyi 2 Medical	ng Physician: To the bes Examiner: On the basis and manner s	of examination a	ge, death and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner as te and place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certific	or A			29c. License	number	29	d. Date signed (Mont	th, Day, Year)
)			1/horas	C. How	nans	Dr.	DOOL	7591	1	December	19 2004
1 1	Le !		30. Name and address of person	who completed cause of	death (item 23a	a) (Type, F	Print)			- CONTINUE	19,2004
2	•		D' neuma	n 1110 1	Tedical	Ca	mpus 1	Ed 1	tog pla	1. 2/74	2_
	Sta Registr	te ar	31. Date filed (Month, Day, Year DEC 2	2 2004 32. Begis	trar's Signature	de	ufe		l		

	State of Maryland / Department of Health and M	lental Hygie	*ne2006 1:1663
	1 - State State Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg 2. Date of Death	J. No. 3. Time of Death
Physician /Medical	Florence Edna Mae Hynson	December 6	Day Year
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
	Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	P. Date of Righ	191bot
Funeral Director	215-26-5410 1 M 2 F 74 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Aug. 18, 1	
pua M	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1105,10,1	10d. Inside City Limits
Maryli find a			1-d Yes 2 No
6 after death with the Ma or iteme 23a or 28s-f so or ar must be redified	Maryland Queen Annes Grasonville 10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?
ath wi	27 Grasonsille Terrace 21638		USA
fter de	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Never Married 2 Married 1 1 Yes 2 2 No	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036 72 hours after death with the Maryland natural", or items 23a or 28s-f show digal Exart and murmusite invitinal at steed by Filmeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: Black
21215-00 ed within 72 ho ygiene. Per then "natura is, the Medicals is, the Medicals is."	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of works life. DO NOT use retired)	ing 16	b. Kind of Business/Industry
2121 2121 3 within 3 jene.	Elementary/Secondary (0-12) 12 College (1-4or 5+) Seafood Shucker		eafood Industry
land 2 lid be filed ental Hygin ked other ic svent, in		e (First, Middle, Ma	
farylanc 2 should be fand and Marked of is marked of its marked of is marked of is marked of is marked of its marked of is marked of its ma		e Hynson	
SON, FIORENCE re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hyglene. tiem 27 is marked other then "natural", or iteme 23e or 28e-f show other treumstic event, the Medical Exam at must be retified at To Be Completed by Funeral Director	Betty Lee spence / Daughter 105 Holton Street, Cer		
			c. Location - City or Town, State
Limor Fages Thent of Tent: If it	'4 Donation 5 Other (Specify) Carmichael Cemetery 12/18	8/2004	Carmichael, Maryland
Baitimo	21. Signer of Foheral Service Licensee 22. Name and Address of Facility Bennie Smith Fund 426 Dover Street	eral Home , Easton,	Maryland 21601
	23a. Part 1. 5 her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arrest	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructure Polymona. Due to (or as a consequence of):	TX Dis	e95-e
Examiner		/	
sk sk	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
760, be executed sicien and burial-transit	that initiated events resulting in death) Last Due to (or as a consequence of):		
8760, cate be executed physicien and the burial-transit	d		
	IF FEMALE:		
P.O. Box 6 nat the death certific by the attending I letached for use as Physician/Me	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Year
P.O. that the deby the detached	1 Yes 2 Wo 9 Unknown 5 Other (specify)		
IS, F res tha igned be del by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?
cord w requir been si should I	· · · · · · · · · · · · · · · · · · ·	-	2 No 3 Probably 4 Naknown
Has has		24a. Was an autopsy performed	
Vital Ficien: The certificate rector, page	25. Was case referred to medical examiner? 26. Place of Death	1 Yes 2 Check on one	No 1 □ Yes 2 No
Of V Physic this ce al direc	1 Yes 25 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor		
C P P P P P P P P P P P P P P P P P P P	27. Manner of Death 1	28d. Describe how i	njury occurred
Division c tal or Attending P is after death. el Director: After t ed in by the funera Certification:	2 Suisite 6 Could not be	28f. Location (Stree City or Town, S	at and Number or Rural Route Number,
Distal or urs after in led in Cer			
Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be 6	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place at the my knowledge, death occurred at the time, date and the my knowledge, death occurred at the time, date and the my knowledge, death occurred at the time, date and the my knowledge, death occurred at the time, date and the my knowledge, death occurred at the time, date and the my knowledge, death occurred at the my knowledge, death o	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier 29c. License number		Date signed (Month, Day, Year)
	Jenn Jo Hald D065311	O lec	ember 1/ 2004
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShields M D , 219 S. Washington Street, Ea	ston.Mars	vland 21601
State	31. Date filed (Month, Day, Year) 32 Registrar's Signature		2001
Registrar	DEC 1 5 2004 Som B. South		

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F			giene Reg. No. 2004	41663
ı	Physic		Decedent's Name (First, Middle, Last) Duglas Let					2. Date of Dea	er 07, 2002	3. Time of Death 2155 P M
	/Medi Examii		4a. Facility Name (If not institution, give s 3354 Chillum Road			Mount F		th	4c. County of De.	ath
	Funeral Director		5. Social Security Number 21.3-08-3732 Usual Residence of Decedent	7. Age	(In yrs. last birthday) 21 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da)		rthplace (State or Foreign country) shington, D.C.
	a-f show	ctor	Maryland Prince Geo	orge's	10c. City, Town or Lo		⁄bunt Rain	ier		10d. Inside City Limits 1 □X es 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 3354 Chillum Road Apt.	#201		10f. Zip Code	20712		10g. Citizen of What C	country?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mentat Hyglene. If itiam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic event, the Medical Example routh to rottling at	b	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2000 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	_	
Maryland 21215-0036	filed within 72 h Hygiene. ythar than "natu ant, tha Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(Give	dent's Usual Occup kind of work done DO NOT use retired ick Mason	ation during most of wo	orking .	16b. Kind of Business Self-Employ	,
yland 2	2 should be filed withir and Mental Hygiene. Is marked other then sumatic event, the M.	To Be C	17. Father's Name (First, Middle, Last) Droplas Hamir	101/12IV				me (First, Middle, Brenda Lee		
	1 and 2 sho Health and am 27 Is ma		19a. Informant's Name/Relationship (Ty, Mrs. Brenda L. Hemingw				and Number of F ad Apt. #2	on Route Number (01 Mount R	r, City or Town, State ainier, Maryl	zip Godel and 20712
Baltimore,	permit. Pages 1 Department of He Important: If itan any injury or oth		20a. Method of Disposition 1 ∰Zurial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crer Resultrection	esition (Name of matory or other place n Cenetery	Decemb	Date er 15, 2004	20c. Location - City of Clinton, I	
Balt	permit. Pag Department Important: any injury o		21. Sign turn of Funeral Service License	nders	On 1	2. Name and Addres	lace, N.E.	Washington		_
	Fnysician /Medical		23a. Dany. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Blunt	the death. Do not ent e			the h		Approximate Interval Between Onset and Death
8760,	ate be executed hystician and the burial-transit	ıl Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Unidentying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
.O. Box 6	The law requires that the death certificate tte has been signed by the attending physioage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.		bacco use contribute t es 2∯No 3□P	o the cause of death?
Vital Records,		Completed						24a. Was a autops perform 1 N Yes	sy prior to	utopsy findings available completion of cause of
Division of Vit	Attending Physician: " r death. actor: After this certifica oy the funeral director, p	ertification; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 🗆 Inpatien 28a. Date of Injury (Month, Day)	Year) 28b. Time of Injury		er: 4 ☐ Nursing I	28d. Describe he		city) At scene
Divis	in Diffe	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.	stre	eet		Mont Ra	treet and Number or Rin, State) 3354 iner mD	chillum Rd
	Hos Funda ely	edical	29a. Certifier (Check only one) 1 ☐ Certifying Phys 2 ☐ Certifyi	ician: To the best of er: On the basis of and manner state	examination and/or inv	n occurred at the tim restigation, in my op	ne, date and place pinion, death occ	e, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To tha I within 2 To the I complet	M	29b. Signature and title of certifier	mid		29c. License 0.C.N			9d. Date signed (Mont December 08	
_			30. Name and address of person who con	>	111	Print) Penn Str	eet, Ba	Ltimore,	Maryland	21201
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 2004	2. Registrar	's Signature	E)				-

			1 - For State Registrar	State of Marylar	nd / Depa	artment rtificate	t of He	ealth and N Death		giene 004	41664
		Ш	1. Decedent's Name (First, Middle, Last)			-			2. Date of Dea	ith	3. Time of Death
	Physici /Media		Edwin William Hun	dertmark					Month December	Day Yea r 10. 2004	M
	Examir		4a. Facility Name (If not institution, give s			4b. City,	Town, or L	ocation of Death		4c. County of De	
۵	Funeral		Montgomery Hospic 5. Social Security Number 6. Sex	7. Age (In yrs.	e . last birthday)	If Under Months		ville If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		irthplace (State or Foreign
	Director		254-40-6293	M 2□F 7	6 Yrs.	IVIONINS	Days	Hours Will.	Aug. 30		orgia
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	fah	5									1 ☐ Yes 2 ☑ No
	28a-	Director	Maryland Montgome	ry	Silver	Spri				10g. Citizen of What (
	with le or	ā				101. 210	0000			rog. Citizen of What C	Sountry:
	ns 23	era	2104 Cherry Leaf L	ane 12. Was Decedent Ever in U	J.S. 13.	Was Deced	ent of His	20906	ecify Yes or No-	USA 14. Race - An	
36	d within 72 hours after death with the Maryland jene. Ir than "neturel" or Items 23e or 28a-f show The Madical Ever interrinal by nailfied at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ¬Yes 2 □ No If Yes, Give Kore	a,	If Yes, spec		Mexican, Puerto	pecify Yes or No- Pican, etc.)	Black, Wh	
21215-0036	ture	ed	15. Decedent's Educ			dent's Usua	l Occupat	ion		16b. Kind of Busines	hite
15	in 72 n "nel	Completed	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done du	ring most of work	ing	TOD. KING OF DUSINGS	amustry
212	d within jiene. r than "	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Off	icer				US Army	
헏	othe ent,	Be C	17. Father's Name (First, Middle, Last)				1	8. Mother's Nam	e (First, Middle, i	Maiden Sumame)	
<u>a</u>	uld be Aental rked o	ToE	Herman William Hun	dertmark				Agnes	Saunder	rs	
Maryland	2 should be and Mental Is marked araumatic ev		19a. Informant's Name/Relationship (Type	pe, Print)	19b. Mailir	ng Address	(Street an			r, City or Town, State,	Zip Code)
altimore, M	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic events.		Hildegard Hundertm 20a. Method of Disposition 1 Regurial 2 Cremation 3 Reg	20b.	2104_ Place of Dispo cemetery, crer ington	sition (Nam natory or ot	le of her place)		Silver	Spring Ma 20c. Location - City o	ryland 20906 or Town, State
를	artme ortani injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service License		Ce	meter	У	Jan.	19,2005	Arlington,	Virginia
Ba	Department of the partment of		1 Chrohen S	1 Cole	Fr 50	ancis O Uni	J. vers	Collins ity Blvd	.,W.,Sil	Home, Inc Lver Sprin	e.MD 20901
П			23a. Part1. Enter the disease, or compli shock, or heart failure. List on, on	dations that caused the dea cause on each line.	th. Do not ent	er the mode	of dying,	such as cardiac	or respiratory arri	est,	Approximate Interval Between Onset and Death
	Enysician		Immediate Cause (Final disease or condition	Metastatic 1	Maligna	nt Me	1ano	na .			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec			2001001	,,,,,			
100		-	Sequentially list conditions, b								
	sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	querice oi):						
_	and and Il-trar	Examin	that initiated events cresulting in death) Last	. Due to (or as a consec	quence of):						
8760,	cate be executed physician and the burial-transit				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
387	icate phys s the	dicai	d								
×	es that the death certific gned by the attending E be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancy					23d. Date of de	olivon
Вох	atter I for u	Physician/M	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3□	Ectopic pre Other (spe				Month Month	Day Year
O	the d y the	ıysi	1 Yes 2 No 9 Unknown	9□ Unknown		2 0 0 0 0 0 0 0					
ص	The law requires that ite has been signed b bage 2 should be deta		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying ca	use given	in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Records,	juires n sign	d by							1 ☐ Ye	es 2⊊No 3⊟F	robably 4 Unknown
000	w requir been si should	Completed							24a. Was a	n 24h Were a	utopsy findings available
Вe	The lav	ш							autops	v prior to	completion of cause of
Vital		Ö	25. Was case referred to medical					20. 21 / 2		24	s 2□ No
Ē	Physicien: this certific ral director,	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DO	Other		h (Check only on		anif JTT
of			27. Manner of Death	28a. Date of Injury	28b. Time of		c. Injury a	ıt		ance 6 ☑Other (Spenior injury occurred	HOSPice
on		tlo	1 🛣 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Ye	s 2 No			
Division	I or Atten after deatl Director: In by the	ific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str	eet, factory,	office			reet and Number or F	Rural Route Number,
ā	et or A s after II Direct	Certification:	4 Normalde	building, etc. (Special	Ty)				City or Town	n, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral completely filled in by the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral completely filled in by the funeral completely filled in by the funeral completely filled in the funeral completely filled in by the funeral completely filled in the funeral comple	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred a	t the time, in my opin	, date and place, nion, death occur	and due to the cared at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	ompl	Me	29b. Signature and fills of conflier	10		29c.	License r	number	29	9d. Date signed (Mon	th, Day, Year)
	1		& CROKET	the		1	14	1218		10/10	104
	17		30. Name and address of person who col	mpleted cause of death (Iter	n 23a) (Type	Print)	J /	12+0		14/10	/ 0 /
			Charles M. Harriso				M:11	Doc-J D	0.01	MD	
	. Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		ster		RUAG K	ockville	, WIII	
	Registr	ar	DEC 13 200	14 Serevas	13	200	eles				

EWIN Hundytmark

			1 - For State Registrer	State of Mar	yland / Depa <i>Cei</i>	artment of F	lealth and <mark>I</mark> Death	Mental Hyg	giene 00 L	41665
			1. Decedent's Name (First, Middle, L	ast)				2. Date of Dear	th	3. Time of Death
Н	Physici /Medic		Nancy	Hendricks	Law			1	r 7, 2004	2:45 A. M
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	Location of Death	1	4c. County of Dea	th
		L	Shady Grove Adve			Rockv			Montgom	
	Funeral			Sex 7. Age ((In yrs. last birthday) 79 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director		218-20-0601 Usual Residence of Decedent		79			June 18	,1925 Wasi	nington, DC
	yland yland		10a. State 10b. County	1	IOc. City, Town or Lo	cation	-			10d. Inside City Limits
	a-fsh	ctor	Maryland Montgon	nery	Gaithers	sburg				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a		419 Russell Aver	ue, # 307		20877			USA	
	tems	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp In, Mexican, Puerto	pecify Yes or No- D Rican, etc.)	14. Race - Am Black, Whi	
36	filed within 72 hours after death with the Maryland Hygiene. Ither then "natural; or ttems 23a or 28a-f show ent. It a Maralcal Exama ar must to motified at	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 21 No	Specify:		Specify:	
5-0036	tura tura	edt	15. Decedent's		16a, Decer	ient's Usual Occup	ation		16b. Kind of Business	nite Andustr
212	n "n	Completed	(Specify only highest g	rade completed)	(Give	kind of work done o DO NOT use retired	during most of work	king	100.14110 01 203111033	moustry
212	d with	E O	Elementary/Secondary (0-12)	College (1-4or 5+) 4		cial Worl	ker		Montgomery	County
9	al Hy rothe	Вес	17. Father's Name (First, Middle, Las	it)			18. Mother's Nam	ne (First, Middle, M	Maiden Sumame)	
Maryland	Ments Ments arked arked	To	Harry	Hendricks				Frances	s Almira	Lee
ar.	and and le m		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Number	, City or Town, State,	Zip Code)
2 (i)	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene a fitten 27 1e marked other then "natural", or items 28a or 28a-f show other traumatic event. It is Medical Exam and must be redified at		Robert L. Pillot	e, Jr./Attor						
<u>o</u>	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Burial 2 🏝 Cremation 3	Removal from State	· ·	natory or other plac	e)		20c. Location - City or	, , , , , , , , , , , , , , , , , , , ,
	tant:		`4 □Donation 5 □ Other (Spec							ı, Virginia
ga	permit. Pages Department of I Important: If its any Injury or o	-	21. Signature of Funeral Service Lic		/ . M .	. Name and Addres				
	40200		23a. Part1. Enter the disease, or co	To ligations that caused the	occito Donatori				hersburg,	
10			shock, or heart failure. List only	y one cause on each line.	e death. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Sepsis						Silver and South
	Examiner				consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Pneumonia	consequence of):					
	uted d ansit	min	if any, leading to immediate cause. Enter Underlying Cause (Leaders of Iriju y							
ń	exection and ital-tra	Examine	that initiated events resulting in death) Last	C Due to (or as a c	consequence of):					
8/60	cate be executed physicien and the burial-transit	dicai		▲ d						
		Medi	15.55141.5							
X Q R	death certific e attending p	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy			23d. Date of de	
	e dea he att	sicia	in the past 12 months? 1 Yes 2 No	4□Pregnant at tin		Other (specify)			Month	Day Year
r Ö	that the de led by the a detached t	Phy	9 Unknown					00 P:444		
S	w requires that been signed t should be det	by	Part II. Other significant conditions	contributing to death but i	not resulting in the ur	iderlying cause give	en in Part I.		acco use contribute to	
Ö	requires been sign hould be	eted						1 10	s 2⊈No 3⊟Pr	obably 4 Unknown
Kecora	e la has	ompieted						24a. Was ar autopsy perform	y prior to	topsy findings available completion of cause of
_	Th pag	O							No 1 ☐ Yes	2 □ No
Vital		o Be	25. Was case referred to medical examiner?	Hospital:	- C 55/2	Othe	AC.	h (Check anly and		
o	ding Phys	-	1 ☐ Yes 2X No 27. Manner of Death	1 28a. Date of Injury	2 ER/Outpatient	28c. Injury	4 Iduising He	ome 5 Resider 28d. Describe hor	nce 6 Other (Spe winjury occurred	cify)
Sion	iding th: Afte fune	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Injury	Work	(? /es 2 □ No			
<u> </u>	Atter r dea sctor by the	ertification;	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury	- At home, farm, stre	et, factory, office		28f. Location (Str	reet and Number or Ru	ıral Route Number,
<u>≥</u>	afte safte		4 Homicide determine	building, etc. ((Specify)			City or Town	, State)	
	ospii hour unere ly fille	ical C	29a. Certifier 1 X Certifying F	hysician: To the best of r	ny knowledge, death	occurred at the tim	e, date and place,	and due to the ca	use(s) and manner as	stated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ed	Une)	miner: On the basis of ex and manner state	d.	estigation, in my op	oinion, death occur	red at the time, da	ite and place, and due	to the cause(s)
	To t	Σ	29b Signature and title of certifier	•		29c. License			d. Date signed (Monti	
	12	1				D) 00	61681	1	ecente	8,2004
		1	γ	completed cause of deat		•				
			Mohert D. Kirke 31. Date filed (Month, Day, Year)	aldrun, 99		al Center	Dr., Roo	ckville,	Maryland 2	20850
П	Sta Registr			004 Jener		Sports	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #4a-c PER PHY C839 1/12/05 JH 2. Date of Death 3. Time of Death **Physician** Month Dec. Mary Michael Foster Johns 2004 5:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death

ANNE ARUNDEL Examiner 10020 Mila Street 514 HARLEQUIN LANE Denton SEVERNA PARK
If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sep. 11, 1940 **Funeral** Birthplace (State or Foreign Country) Days 1 □ M 2 🛛 F Months 64 Director 220-36-4760 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Itams 23a or 28a-f ahow Director MD 1 ☑Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6710 Ridge Road 21246 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☒ No White Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Lippencott, Williams Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If itam 27 is markad othar than Elementary/Secondary (0-12) College (1-4or 5+) & Wilkens Executive Secretary 12 traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard I. Foster, Jr. Elizabeth J. Butler P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. MacDonald/Daughter 10020 Mila Street, Denton, MD othar 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Baltimore, MD Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician Hachocarcinoma mas resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Cher (Specify) Daughter's 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: / the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) tha 29b. Signa ure and title of certifie 00025773 of death (Item 23a) (Type, Print)

E 1650 ORLEANS ST BAHTIMORE, MO 21231 Name and address of person who completed cause of RLENE A. FORASTIERE

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month

DEC 15

2004

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2004 Regina December Kwaraceius 3:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16100 Penn Manor Lane Prince George's Bowie 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2**/□**XF 252-82-5501 Yrs Director 67 Ukraine Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or Items 23e or 28e-f show eny injury or other treumetic event. The Medical Examinar must be retified at once. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Be Completed by Funeral Director Md. Prince Georges 1 Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16100 Penn Manor Lane 20716-1731 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔼 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation

16a bind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Beautician Haircare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 Edmund Jeske Frosinie Titofski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph John Kwaraceius-husband 16100 Penn Manor Lane, Bowie, Md. 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 12-10-04 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funer Wervice Licensee 22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary artery disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertension Physician/Medical Examiner burial-transit Ď Be Completed P

the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, filled in by the funeral after death hin 24 hours a

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (cras a consequence of). Diabetes			
	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
			24a. Was an autopsy performed? 1 ☐ Yes 2 X No.	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing He	ome 57 esidence	6 Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred
1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determined		et, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death miner: On the basis of examination and/or invented and manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause(s red at the time, date an) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d Da	te sinned (Month Day Year)

29c. License number

39030

29d. Date signed (Month, Day, Year)

12/10/04

Registrar DHMH 17 Rev 1/2001

State

N P

29b. Signature and title of certifier

Urvi Mehta MD,

DEC 1 0

us relita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1132 Annapolis Rd., Odenton, Md. 21113

LID

CPM 04 - 08152Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Martina Kamin-A-Kalan State of Maryland / Department of Health and Mental Hygiene

1- For Amend Item 1&4a&Unpend Item 23a, 27, 28a-f per me G840 2-17-05 tas
Reg. No. 2 1 1. Decedent's Name (First, Middle, Last) 2 Date of Death December 18, 2004 **Physician** 10:19 A M Martine O'Kassa Kamin-A-Kalaw /Medical 4a. Facility Name (If not institution, give street and number)
821 Snyder Lane 821 Snider Lane 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 ☐ M 2 🔀 F Yrs Director 013-46-2903 53 27, 1950 Dec. Congo, Africa Usual Residence of Decedent Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic avant, Ita Medical Erus is at mast be redified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 821 Snider Lane 20905 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after Never Married 2□ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within. In and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 5+ Outreach Liaison Medical 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Kalaw 2 Martha Toko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health in tam 27 is other tra 821 Snider Lane, Silver Spring, Md 20905 Gabriel D. Kalaw/Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State December 24, Gate of Heaven ₹ Department of Important: If it any injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2004 Silver Spring, Marylan Francis Address Compins Funeral Home Inc 500 University Blvd, W, Silver Spring, Md 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carbon monoxide intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last ysician a e burial-t Due to (or as a consequence of): Box 68760 Physician/Medicai β nding p IF FEMALE ase. 23c. If yes, outcome of pregnancy
1□Live birth 2□Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 0 Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No has 1 Yes Division of Vital 2 🗆 No Physician: 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA ٢ 28c. Injury at Work? 27. Manner of Death (Found) 10:05 28d. Describe how injury occurred Certification: After To the Hospital or Attending 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2X No 2X Accident malfunctioning furnace 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State 21 Snider Lane 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Residence Silver Spring Ridge, Md within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated. 29b. Signature and title of certifier

State

Registrar

RUBIO, MD

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E. December 20, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 27 2004

32. Registrar's Signature

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	29b. Sig	Mec		Sideo.		29c. Lice	ense number		29d. Date signed	(Month, Da	y, Year)	
D09157 Dec 24 2004	•	- 5 - 0	1 6. 8	how		חמ	9157	l.				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	30. Nam	5	30. Name and address of person who co-	mpleted cause of death (Ite	em 23a) (Type.		2131		DEC 24	2004		
Dr Paul Snow, 124 W. Third St, Cumberland, Md 21502							and, Md 2	1502				
State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature Registrar DEC 2 7 2004		Otate	31. Date filed (Month, Day, Year)		nature	2 40						

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day Year **Physician** 21, 2004 December 4:00 AM Kisselovich /Medical Joseph Victor 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Garrett County Memorial Hospital 0akland Garrett If Under 1 Year If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M M 2 □ F Yrs. Director 197-14-7526 78 April 30,1926 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director 0akland MD Garrett 10f. Zip Code 10g. Cilizen of Whel Country? 10e. Street and Number 21550 Funeral 604 E. Oak Street USA 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Slalus Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: WW II 1 ☐ Never Married 2 Merried Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 8th Foreman State Highway 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kisselovich Clara Stachurski Joseph. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 604 E. Oak Street, Oakland, Md. 21550 Joyce L. Kisselovich/Wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State 12/26/04 Morgantown, WV 4 ☐ Donalion 5 ☐ Other (Specify) Omega Crematory 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility 32 S. Second St. Stewart Funeral Home Oakland, Md. 21550 line 23a. Part 1. Enler the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical sudden Examiner e. Cardiac Arrhythmia Due to (or es e consequence of): Physician/Medical Examiner Acute Renal Failure weeks To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Chronic Renal Insufficency weeks Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Non Ischemic Cardiomyopathy Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was en autopsy pertormed? 1 Yes 2₺ No 1 Tyes 2 No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpalient 2 X ER/Outpalient 3 DOA 27. Manner of Death 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNaturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a, Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D23979 12/21/2004 ed cause of deeth (Ilem 23e) (Type, Print) 30. Name and address of person who compile M.D. 311 N. Fourth St., Oakland, Md. 21550 Robert A. Goralski 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature DEC 23 2004 Registrar

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 11 2004 Sheldon Hoard Kinney 7:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death **Examiner** 2515 Carrollton Road Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Aug. 27, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 2 □ F 86 Yrs. Director 212-38-7940 1918 California Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10a State 10h County 10d. Inside City Limits ns 23e or 28e-f show must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2515 Carrollton Road 21403 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 🖺 Yes 2 □ No 1936— If Yes, Give Year or Dates: 1972 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 1972 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Admiral United States Navy treumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H Be Harold Kinney Gladys Hoard ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu 3187 Avcliff Court_ Capt. Bruce Harold Kinney / Son Smellville, Georgia 30039 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 12/12/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Dlom 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SGUAMOUS CELL CARCINOMA OF disease or condition resulting in death) ONE /Medical Due to (or as a consequence of):

THE LEFT PAROTID YEAR **Examiner** Sequentially list conditions, if any, Isaamy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequency of Physician/Medical Examiner burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPONATREMIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 No 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 🗌 Yes Certification: To 27. Mann of Death 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury after death. 1 □ Yes 2 □ No 2 Accident filled in by the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 038328 - MOMPH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MCLANCE 116 DEFENSE ITWY SUITE 400 ANNAPOLIS

MO 21401 32 Registrar's Signature State **DEC 13 2004** Registrar

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	Physici	an	Decedent's Name (First, Middle, Last) Naomi R.		To	scalle		5 07 2	Joann	Ī	2. Date of Dea	Day	/ Ye	ear	3. Time of Seath 2
	/Medi Examir		4a. Facility Name (If not institution, give si	treet and number)		SCALLE		Town, or	Location o		Decembe		3, 200 County of E		8:30 A M
	LXaiiii	101	12128 Woodsboro	Pike				Mid					Frede		
	Funeral Director		217-03-4552	M 2 ☼ F 7. Ag	e (In yrs. I 87	last birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Oct. 21,	1917	9. M	Birthpla Counti	ace (State or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
	Maryl f sho	to	Maryland Frederic	k	Ne	w Midw	ay								1 ☐ Yes Ž ☐ No
	h the	Director	10e. Street and Number		<u> </u>		10f. Zip	Code				10g. Cíti	zen of Wha	it Counti	ry?
	23a c		12128 Woodsboro	Pike			2	21775	,				USA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. If a Modical Examinatory and be notified at once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:		'	Vas Deced Yes, spec		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)		14. Race - A Black, V Specify:	America White, e	tc.
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Balt	permit. Depart Import any inj		21. Signature of Fuperal Service Literate	<u> </u>			Name and			Sta	auffer :				
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0	nding tth, :: After e funer	atior	1	(Month, Day	í Year)	Injury	М	Work?	5" es 2 □ N		54. D030/100 11	Jiv illijary	occurred		
Division	al or Attanding F s after death, I Diractor: After d in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubul	ıry - At hor c. (Specify)	me, farm, stre	et, factory,	office		2	8f. Location (Si City or Town	treet and n, State)	l Number or	Rural P	Route Number,
	To the Hospital or within 24 hours after To the Eunaral Director Completely filled in b	edicai (29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of er: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred a estigation,	t the time	, date and nion, death	place, a	nd due to the co	ause(s) a ate and p	and manner place, and c	r as state due to th	ed. ne cause(s)
	To ti withii To ti	M	29b. Signature and title of certifier	/			_	License			1		signed (Mo		
			11/1 chael	Lern	- 1	1.0		9 41	619			Dec	enlu	-1	3, 2004
	1		30. Name and address of person who com Dr. Michael Ler				,	Dν	Erod	oric	1 _r MD 0	1701)		
	Sta	te	31. Date filed (Month, Day, Year)	ner 03			-		rred	eric	k, MD 2	1/02	-		
1	Registr		DEC 17		Born o	N.	Krack	0 9							

			1 _ For	State of Maryland	-			lental Hy	giene	2001	1.1672
			Ragistrar 1. Decedent's Name (First, Middle, Last)		Cel	tificate of E	Jeath	2. Date of De	Rag. No		3. Time of Death
	Physici /Medic		MOLLIE KAT	E LATHAM				DECEMB	ER 1	4, 2004	
	Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c.	County of Dea	
	Funeral		VILLA ROSA NURSING 5. Social Security Number 6. Sex	TOME 7. Age (In yrs. las	t birthday)	BOWIE If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth.	INCE GE	URGE'S
	Director		215-48-2874	M 2X□ F 95	Yrs.	Months Days	Hours Min.	APRIL	26, Year)	1909 ₹	TRGINIA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	Town or Lo	cation					10d. Inside City Limits
	e Mary a-f sh	ctor	MARYLAND CALVERT	POR	RT REI	PUBLIC					1 ☐ Yes 2X No
	with the	Dire	10e. Street and Number	A T 1		10f. Zip Code			-	zen of What C	•
	ms 23	Funerai Directo	5035 TIMBERWOOD TRA		13. \	Nas Decedent of His f Yes, specify Cuban		ecify Yes or No		ITED ST	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, the Madical Examiner must be multired at	y Fur		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 2 No If Yes, Give	ĺ	f Yes, specify Cubar I□ Yes 2 🛣 No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, Whi Specify:	
5-0036	Phours	ed by	3 XWidowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates:	16a. Deced	lent's Usual Occupa	tion		16b. Ki	nd of Business	WHITE
2	ithin 72 ie. ien "ne	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	completed) College (1-4or 5+)	(Give	kind of work done di OO NOT use retired)	uring most of worki	ing			,
27	filed w Hygier other th		17. Father's Name (First, Middle, Last)			HOME MAKE	- R 18. Mother's Name	(First Middle	1	OWN HOM	E
aryland	should be ind Mental I marked o	To Be	HOMER L. GIBSON					E C. P.			
lary	and and sm		19a. Informant's Name/Relationship (Type			g Address (Street a			-		
e,	1 and 2 Health tem 27		PAMELA S. GIBBS - 1 20a. Method of Disposition	20b. Plac	e of Dispo	TIMBERWOO	7			SLIC, Mincation - City or	
altimore,	Pages lent of nt: If if ry or o		1 Burial 2 □ Cremation 3 □ Rel '4 □ Donation 5 □ Other (Specify)	moval from State	-	natory or other place CEMETERY		2004		•	MARYLAND
Balti	permit. Pages 1 an Department of Heal Important: If item 2 any njury or other 2008		21. Signature of Funeral Service Licensee		22	. Name and Address	s of Facility				20604
	<u>0</u> 05 € 0	_	23a. Part1. Enter the disease, or complica	ations that caused the death		JNTT FUNER				o6, WAL	DORF, MD Approximate
Į.	Physician i		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.							Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequer	nce of):	tic the	cont	DISE	cer		Jeans
	Cxammer	er	Sequentially list conditions, if any, leading to immediate	Al a hein	nce of):	8 DIS	ease				years,
	cuted nd ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events		,						
60,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a consequen	nce of):						
68760	- D	edicai	d.								
Box	The law requires that the death certifi to has been signed by the attending bage 2 should be detached for use as	an/M	23b. Was decedent pregnant	c. If yes, outcome of pregnancy		Ectopic pregnancy			2	23d. Date of de	
o.	he dea the at	Physician/M	in the past 12 months? 1 ☐ Yes 2 承No 9 ☐ Unknown	4☐Pregnant at time of deat 9☐ Unknown	h 5□	Other (specify)				Month	Day Year
<u>a</u> .	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions contr	ributing to death but not resulting	ng in the ur	nderlying cause giver	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
ords	v require been sig should b					<u> </u>		1 🗆	Yes 2	Z No 3□Pr	robably 4 Unknown
Vital Records,	The law i cate has be page 2 sh	ompieted						24a. Was autor		24b. Were au prior to death?	utopsy findings available completion of cause of
tai		e C	25. Was case referred to medical				26. Place of Death	1 Yes	2 X No	1 ☐ Yes	2 □ No
	Phyeici r this cer ral direc	To B	1 162 5 VIO	spital: 1 ☐ Inpatient 2 ☐ ER	VOutpatien	t 3 DOA Other	. 4 Nursing Hor			3 □Other (Spe	cify)
Division of	ing Afte une	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	3b. Time of Injury	28c. Injury : Work? M 1 7	at 2 ? es 2 □ No	28d. Describe	how injur	occurred	
XIS!	il or Attendi after death. Director: A I in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre			28f. Location (: City or To			ural Route Number,
	urs after rel Dir						,				
	e Hospitel or At 124 hours after d e Funerel Direct letely filled in by	edicai	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the time restigation, in my opi	e, date and place, a inion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	_		29d. Date	e signed (Mont	h, Day, Year)
,			Kakgl	nounda	M		0108		12	2/15	104
1	Bh		RAKESH ARORA, MD,				IIE, MARY	LAND 20	715		
	Sta			32. Registrar's Signature			<u> </u>				
	Registr	ar	DEC T O TO	O T	1	CALLY CONTROL OF THE PARTY OF T					

		For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of Hertificate of E			ene g. No.2 0 0 L	41674
,		1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day Yea	3. Time of Death
Physici /Medi		LaBaron L. Le	wis				Month	2 200	
Examir		4a. Facility Name (If not institution, give s Chesapeke Ho	SPICE		4b. City, Town, or Linthum	1		4c. County of De	eath RUNDEL
Funeral Director		455-12-9131	7. Age	(In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 2/9/19	Year)	Birthplace (State or Foreigr Country) EXAS
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Manyl f sho	ō	MD P.G.		Upper Ma	rlboro				1 TYPS 2 □ No
28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
h with	O	9803 Stonewood	Ct.		207	72		U.S.A.	
72 hours after death with the Maryland naturel', or Itams 23e or 28e-f show Jical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? C 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	ver in U.S. 0/10/68 9/30/88	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ar Black, W Specify: B	
72 hours "naturel",	Completed	15. Decedent's Edu- (Specify only highest grade	cation	16a. Dece	dent's Usual Occupa kind of work done d	tion	kina 1	6b. Kind of Busines	ss/Industry
within 7 ene. than "n	ple	Elementary/Secondary (0-12)	College (1-4or 5-	lite.	DO NOT use retired)	uning most of wor			
D 0 1	Con		5+	Maj.				Militar	У
id 2 should be filed the and Mental Hyg 27 is marked other traumatic event,	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M		
should be nd Mental i marked c	2	Johnnie Lewis I					Mae McH		T- 0-4-1
d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type	'		ng Address (Street a			•	
- m - =		Geneva Lewis/W 20a. Method of Disposition	rie	20b. Place of Dispo	V1200	ood CL.		Oc. Location - City	o, MD. 20772 or Town, State
S to L		1 DBurial 2 DCremation 3 DR	emoval from State	cemetery cre	matory or other place	ery 11/			
		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensy			2. Name and Addres				
permit. Departr Importe eny inje		21. Signature of Funeral Service Licens	colina	1		HC	odges an	d Edwar	ds
		23a. Partyl. Enter the disease, or compli	cations that caused		910 Silv				Approximate
		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line	9.		,, 000// 20 02/0/20			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	- Fire	a Car	7501				Syeas
Examiner			Due to (or as a	consequence of):	1 -1	A 4			2.
	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequation of).	etasta	515			Sheors
uted Insit	min.	cause. Enter Underlying Cause (Disease or injury	9.		Aire	nder			Syears
be executed sician and burial-transit	Examin	that initiated events resulting in death) Last		consequence of):					G , Con
ate be hysicia he bur			1						
	Physician/Medical								1
eath certific attending p for use as i	N/C	23b. Was decedent pregnant	3c. If yes, outcome of 1□Live birth		Ectopic pregnancy			23d. Date of	,
ne deat the att	Sic.	in the past 12 months? 1 \(\sum \text{Yes} 2 \sum \text{No} \)	4☐Pregnant at t		Other (specify)			Month	Day Year
that the d ed by the detached	h	9 Unknown					- 1		
es tha igned be de	by	Part II. Dther significant conditions con	ntributing to death bu	t not resulting in the u	inderlying cause give	n in Part I.			to the cause of death?
w require been si should t							1 ∀ Ye	s 2□No 3□	Probably 4 Unknown
e law re has be je 2 sh	Completed						24a. Was ar autopsy	prior 1	autopsy findings available to completion of cause of
	TO.						perform 1 ☐ Yes 2		? es 2□No
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one	9)	
g .s .g	70	1 Yes 2 No	lospital: 1 🔲 Inpatier	nt 2 ER/Outpatie	nt 3□ DOA Othe	er: 4 🗆 Nursing H	ome 5 🗆 Reside	nce 6 Dother (S	pecify) 105/116
ding Phy h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	of 28c. injury Work	at	28d. Describe ho	w injury occurred	
Attending r death. ector: Atter by the fune	atle	2 Accident Investigation			M 1 🗆 1	res 2 □ No			
or Attencater death Director: in by the	tifle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Str. City or Town		Rural Route Number,
tel or A rs after el Dire ed in by	Certification:	,							
To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical	(Check only 2 Medical Exami	ner: On the basis of	f my knowledge, dear					
라 듣 다 요	ledi	one)	and manner sta	ted.					
12 ¥ 5 8	Σ	29b. Signature and title of certifier	- 0	2 14727	29c. License			od. Date signed (Mo	
J		Tuta 2	Denne	tee	1000	4786	9	18100	N900H
		30. Name and address of person who co		eath (Item 23a) (Type	drews Y	TER Y	10 2x-	100	
					10 Locus		50	00	
		NOV 2 4 2004	7 32. Registra	r's Signature					

			1 - State of Maryland / D		Death	lygiene Reg. No.2001	
	Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) Ronald Wayne Moats 4a. Facility Name (If not institution, give street and number)	Ab Ch. T		Day Year BER 19, 2004	02:02 a.M
	Examir	ner	Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	4b. City, Town, or CUMBERLA	ND	4c. County of De.	7
	Funeral Director		45714 0515	rs. Months Days	Hours Min. 8. Date of (Month, Dec.	24, 1954 Mai	rthplace (State or Foreign country) ryland
	Maryland	tor	10a. State 10b. County 10c. City, Town Maryland Allegany Cumber				10d. Inside City Limits 1 X Yes 2 ☐ No
	vith the	Direc	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	eath v	eral	38 Blackiston Ave. 11. Marital Status 12. Was Decedent Ever in U.S.	21502		USA No- 14. Race - Am	niana ladian
980	ours after d rel', or Item Eva⊤iner	by Fun	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:	If Yes, specify Cubar	spanic Origin? (Specify Yes or not	Black, Wh	ite, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28e-1 show event. The Medical Evanifier must be notified at	Completed by Funeral Director	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	ition uring most of working	16b. Kind of Busines:	s/Industry
d 21	filed within Hygiene.		12 Di	sabled	18. Mother's Name (First, Midd	N/A	
an	be od o	To Be	John Luther Moats		Marlee Frances	,	
lary	2 2 2 3				nd Number or Rural Route Num		Zip Code)
	other tr	1		W. Baltimor			
nor	of of		I GOUNAL 2 DOISHINGTON 3 DINGHIOVALITOR STATE	Disposition (Name of crematory or other place		20c. Location - City o	
Baltimore,	# 문문·를		21. Signature of Funeral Societies (Special)		ark 12-23-2004 s of Facility Osborne F		,Maryland
m	Depar Impo eny ir		Y in M. Ch.	425 S.Conor	cocheague St.	Williamspor	,r.A. +,MD 21795
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do no shock, or hear values. List only one cause on each line. Immediate Cause (Final disease or condition as ASPIRATION PNEM).	ot enter the mode of dying	, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner		Due to (or as a consequence or SEIZURE (ACUTE)				1 day
,00	sate be executed by sician and the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of cause. Due to (or as a consequence of cause.				
8760,	cate b physic s the bi	edical	d				
O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
α.	res the igned be de	by	Part II. Other significant conditions contributing to death but not resulting in CONGESTIVE HEART FAILURE	the underlying cause given		tobacco use contribute to	
Records,	9 L 9	Completed	STROKE		per	opsy prior to formed? death?	utopsy findings available completion of cause of
	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?		26. Place of Death (Check only		: 2□ No
of V	Phys this al dii	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outp	oatient 3 DOA Other	4 Indising Home 3 Inte		raify)
n	funer	ition		ury Work	at 28d. Describe ? es 2 □No	how injury occurred	
Division	al or Attenas s after deatl il Director: id in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location City or T	(Street and Number or Roown, State)	ural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time or investigation, in my opi	e, date and place, and due to the nion, death occurred at the time	e cause(s) and manner as a, date and place, and due	s stated. to the cause(s)
	V To t	Σ	29b. Signature and title of certifier H. Chotaut	29c. License	number	29d. Date signed (Mont	h, Day, Year)
,	28			D58853		DECEMBER 19,	2004
	-		30. Name and address of person who completed cause of death (Item 23a) (The Habib Chotani M.D. 130 Pennsylvania	ype, Print) 1 Avenue Cum	berland, Maryl	and 21502	
	Sta Registr	-4	31. Date filed (Month, Day, Year) DEC 2 0 2004 32. Registrar's Signature	Breaks			

			1 - For State Registrar	State of Man		artment of F		_	giene Reg. No. 2001	41676	
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) CATHERINE 4a. Facility Name (If not institution, give s		MICKEY	4b. City, Town, o	r Location of Dea	2. Date of De Month th	Day Year 18 2001	ath	
	Funeral Director		Washington County 5. Social Security Number 216-80-5400 1□		n yrs. last birthday) Yrs.	Hagerst If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ly, Year) Peni	on httplace (State or Foreign ountry) nsylvania	
	h the Maryland rr 28e-f show rnotified et	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washingto 10e. Street and Number		Oc. City, Town or Lo	Docation Hagerstov	√n		10g. Citizen of What C	10d. Inside City Limits Y☐ Yes 2☐ No ountry?	
036	be filed within 72 hours after death with the Maryland tall Hygiene. do other than "natural", or items 23s or 28e-f show event, its Manical Exertine It also be notified at	Completed by Funeral D	215 North Mult 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 _Yes _27 No If Yes, Give Year or Dates:	or in U.S. 13.	2174 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No			United Stat 14. Race - Am Black, Whi Specify:	erican Indian,	
121215-0036	led within 72 ho lygiene. her than "natura nt, the Medical In		15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired maker	during most of wo		16b. Kind of Business her ov		
Maryland	ed at b	To Be	17. Father's Name (First, Middle, Last) Angle M. Daley, 19a. Informant's Name/Relationship (Type		19b. Mailie	ng Address (Street	Rache	1 S. Mye	, Maiden Sumame) TS er, City or Town, State,	Zip Code)	
o,	permit Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other treumatic once.		Charles Daley 20a. Method of Disposition 1	.	20b. Place of Dispo	sition (Name of	(9)	Date	rstown, Mar 20c.Location-City of Magerstown,		
Balt	permit Departm Importa any inpu		21. Signature of Funeral Service License Final Local 23a. Part1. Enter the disease, or complice	tal	4	15 E. Wil	son Blv	d., Hage		yland 21740 Approximate	
	death certificate be executed Medical Examiner and physician and for use as the burial-transit	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causs. Entry Unionlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a co	Keuslonsequence of):	monis 7016	ley			Interval Between Onset and Death	
.O. Box 6	the death certifica by the attending phached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of a 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year	
	: The law requires that the de cate has been signed by the e , page 2 should be detached t	Completed by P	Part II. Other significant contained in continuous continuous to death but not resulting in the underlying cause given in Part).								
ion of Vital	Attending Physician: The rideath. ector: After this certificate hiby the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation	26. Place of Death (Check only only only 3 DOA Other: 4 Nursing Home 5 Residue) 28c. Injury at 28d. Describe Work? M 1 Yes 2 No							
É	Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	Specify)			City or To			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2 Medicel Examin 29b. Signature and title of certifier	er: On the basis of ex and manner stated	amination and/or in	vestigation, in my o	pinion, death occ	urred at the time,	cause(s) and manner a date and place, and du-	e to the cause(s)	
	Z Z Z 8		· On	4		D21			12-19-2		
51	Sta Registr		30. Name and address of person who con the control of the control	npleted cause of deatl	Je Hil	Jacobs And	they.	Md. 2	1742		

			For State Ragistrar	State of Marylar		artment of H		_	ene g. No2 () ()	L 41677
	Physicia /Medic Examin	an al er	1. Decedent's Name (First, Middle, Las GERALDINE VIRG 4a. Facility Name (If not institution, give RAVENWOOD LUTHERA)	INIA MOSER street and number) N VILLAGE		HAGERSTO	Location of Death	2. Date of Death Month DECEMBER	Day Ye 20, 200 4c. County of E	4 7:50 P M
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 6. Security Number	9X 7. Age (In yrs. 98	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV . 13	9. 1906	Birthplace (State or Foreign Country) MARYLAND
	the Maryland 28a-f show colined at	Director	10a. State 10b. County MARYLAND WASHIN 10e. Street and Number		ty, Town or L		HAGERST		a Citizen of VAlley	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
036	urs after death v	by Funeral	1183 LUTHER DRIVE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.S. 13.		21740 ispanic Origin? (Spe n, Mexican, Puerto F Specify:			•
1215-0	_ x 30	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	de completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of working ()	19	6b. Kind of Busine	
/land 2	d otl	To Be Co	17. Father's Name (First, Middle, Last) HOWARD G. FORD	2	1	Telle:	C 18. Mother's Name MAUDE EDN			K
e, Mary	1 and 2 sho Health and I am 27 is ma thar traums		19a. Informant's Name/Relationship (7 MARY LOU BOYER/RE	PRESENTATIVE	12 F	ORD AVENU	E, BOONSBO	DRO, MAR	YLAND 2	1713
	permit. Pages 1 a Department of Hez Important: If itam any injury or otha		20a. Method of Disposition 1	Removal from State BO	ONSBOF	osition (Name of matory or other place) CO CEMETER 2. Name and Addres AST FUNER	Y 12/24 is of Facility	/04 B	oc. Location - City SOONSBORG Nationa), MARYLAND
		Exa	23a. Part T. Enter the disease of comp shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	uence of): uence of): uence of):	7	g, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death Uweeks Jeans
irginia, P.O. Box	ed by the attending ph detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
Idine Virgi Records, P.O	eugi pe od	þ	Part II. Other significant conditions co	ntributing to death but not resi		inderlying cause give	en in Part I.	1 🗆 Yes	2 No 3	e to the cause of death? Probably 4 Unknown
I R	certificate has	e Completed	25. Was case referred to medical				26. Place of Death		od? death	
R, on of	After this funeral di	Certification; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	f 28c. Injury Work M 1 1	at 28 ? (es 2 □ No	e 5 🗌 Residenc 8d. Describe how	ce 6 Other (S	
Divi	within 24 hours after death To the Funaral Director: completely filled in by the		4 Homicide determined	building, etc. (Specify	y) wiedge, deat	h occurred at the tim	e date and place ar	City or Town,	State)	Rural Route Number,
		Medical	(Check only 2 Medicel Exemination) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	tion and/or in	29c. License	number	d at the time, date	and place, and c	onth, Day, Year)
0	H-10		30. Name and address of person who c	ompleted cause of death (Item	203	Print) Lappe	ans Ra	Been	Sparo A	2 21,2004 20 21713
:	Stat Registra		DEC 2 3 2	02. registrar s signa	AS A	Lands				

			1 - For State Registrar	State of M	Marylan	d / Depa	artmen rtificate	t of H e of L	ealth a Death	ind Mer	ntal Hygi	ene 20 ()4	4167	3
	.Physici /Medio Examin		A A STATE OF THE S										3. Time of Death	A	
			4a. Facility Name (If not institution, give 937 S. Potomac	r)		4b. City, Town, or Location of C Hagerstown		n n		4c. County of D Washir		on			
	Funeral Director		214-34-0253	7. A	80	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, eb. 29	Year) 9		ace (State or Foreig ry) .10	n
	he Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Washin	gton	1	y, Town or Lo	town				10g. Citizen of What			Nd. Inside City Limits Y□ Yes 2 □ Ne	
	th with t 23a or 2	al Dir	937 S. Potomac	st.			10f. Zip	1740)		10	U.S.A.	at Count	ryr	
036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show fre Maryled Erm idher man be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	;?] No		Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican, Specify:	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Black, Specify.W	White, e	itc.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show entry or other traumatic event, the Machinal Extra litter rotal be notified at ance.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 10th grade		r 5+)	16a. Dece (Give life.	kind of wor DO NOT us	rk done a	turina most	of working	1	6b. Kind of Busin		•	
Maryland 2	uld be filed Jental Hyg rked other	To Be C	17. Father's Name (First, Middle, Last) Famous Blevin								rst, Middle, M nghorn	aiden Sumame) 1			
, Mary	is 1 and 2 should the stand the stand the stand the stand the standard		19a. Informant's Name/Relationship (7 Elaine Moat	anian	ter	19b. Mailir 117	48 Wa	(Street a alnu	nd Number It Po	or or Rural Ro Dint F		City or Town, Sta 1gersto	2011-01-1200		
Baltimore,	Pages 1 ment of He ant: if iten ury or oth		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify		20b. F	Place of Dispo cemetery, crer t. Pai	sition (Nan natory or o ul Ce	ne of ther place emet	ery1	2-23- 2004	- (Oc. Location - Cit Clear S			
Balt	permit. Departifmport. eny inj		21. Signature of Funeral Service Licen:	Tiny		Do	onald O.PC	Ed OX 3	10 C	Thom	Sprin	uneral	Но 217	me,Inc	
	Physician /Medical Examiner	Je.	23a. Part 1. Enter the disea e, ir compositions, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any learning to immediate	a	Mali s a conseq	4. Do not ent	er the mod	e of dying	g, such as o	cardiac or re	spiralory arre	st,		Approximate Interval Between Onset and Death	
98760,	Attending Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the timeral director, page 2 should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c. Due to (or a	is a conseq	uence of):									
P.O. Box 6	the death certify the attending	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Ectopic pregnancy					23d. Date of delivery Month Day Year						
	quires that n signed b	þ	Part II. Other significant conditions co	Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to to the underlying cause given in Part I.								e cause of death?	١		
Division of Vital Records,	The law requir ate has been si page 2 should	Completed									24a. Was an autopsy perform 1 Yes 2	ed? dea	r to com th?	sy findings available pletion of cause of	9
Vita	ysician: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inpa	tient 2	ER/Outpatier	nt 3□ DC	A Othe			heck only one		Specify		_
ion of	nding Phys tth. r: After this e funeral di	ation; T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury				28c. Injury at Work? 28d. Descrit				be how injury occurred			
Divis	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After the cumpletely filled in by the funeral completely filled in by the funeral comple	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	njury - At ho etc. (Specif						ition (Street and Number or Rural Route Number, or Town, State)				
	Hospit 24 hour Funers Funers Funers Funers Funers	Medical (29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	iner: On the basis	of examina	ition and/or in	vestigation,	in my op	inion, deat	th occurred a	it the time, dat	e and place, and	due to	the cause(s)	
	To th To th C mp	Me	29b. Signature and title of certifier	(Do. 1	4		290	License	number		29	d. Date signed (f	Aonth, D	ay, Year)	
•	, X		30. Name and address of person who c	completed cause of	death (Item	N D	Print)	126	1160	67		12.1	1.0	4	_
3) ^t		Michael T.	McCor.	A C C		110	121	10160		Compo	y to	0.41	olay, Year)	_
	Sta Registi		31. Date filed (Month, Day, Year) DEC 22 2	004 32. Progis	gran's Signa	S. A	rente								

				partment of Health and Mental Hygertificate of Death	iene g. 2004 41679					
2	Physic		1. Decedent's Name (First, Middle, Last) James R. Mack, III	2. Date of Deat Month	h 3. Time of Death					
	/Medi Examir Funeral		4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	4b. City, Town, or Location of Death Cheverly	4c. County of Death Prince George's					
	Director		215 19 1482	Months Days Hours Min. (Month, Day, July 20,	Year) 9. Birtholace (State or Foreign Country) 1981 Washington, DC					
	e Marylar Sa-f show Liffed at	ctor	MD Prince Georges Laure1	ocation	10d. Inside City Limits 1½∏ Yes 2 ☐ No					
36	within 72 hours atter death with the Maryland ene. than "neturel", or items 23e or 28e-f show ta Medical Examiner must be rediffed at	by Funeral Director	10e. Street and Number 8301 Ashford Blvd., #217 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Note of the process of the proc		United States 14. Race - American Indian, Black, White, etc. Specify: Black					
21215-0036	filed within 72 hou Hygiene. Ither than "neture ant, I'm Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 1 th 16a. Dec (Gin life life un	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) employeed	6b. Kind of Business/Industry					
Maryland	Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked cury or other treumatic events	To Be	17. Father's Name (First, Middle, Last) James Mack Jr.	18. Mother's Name (First, Middle, M Janice Alexand	er					
			Janice Mack Mother 8301	Ashford Blvd., #217 Laure						
Baltimore,			'4 Donation 5 Other (Specify) Lincoln	Memorial 12/13/2004	Suitland, Maryland					
Ba	permit. Departn Importe any init			22. Name and Address of Facility John T. Rh: 3015 12th St., NE Washingto	on, DC 20017					
	Physician /Medical Examiner	ı	Immediate Cause (Final disease or condition resulting in death) A TULTIPLE GUNS Due to (or as a consequence of):		st, Approximate Interval Between Onset and Death					
8760,	cate be executed obysician and the burial-transit	dical Examiner								
.O. Box 6	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year					
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown					
Vital Records,	ding Physicien: 1. Atter this certifica tuneral director, p	e Completed								
of		ertification; To Bo	25. Was case referred to medical examiner? Yes 2 No	PM 28c. Injury at Work? 1 Yes 2 No SVBJ€C	ce 6 Other (Specify)					
Divi		0	3 ☐ Suicide 4 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. City or Town, State) 53 59 (UINCY PUBLE, High Post of County)							
	the H hin 24 the F nplete	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea Amedical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)					
)	Norith	~	29b. Signature and title of certifier		Date signed (Month, Day, Year) cember 5, 2004					
/			30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 1 Penn Street, Baltimore,	Maryland 21201					
	Sta Registr		31. Date filed (Month, Day, Year) DEC 1 3 2004 P. Registrar's Signature							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11 A Dec. 1 Oay Marie Evangeline Minnick **Physician** /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Frederick Middletown 9136 Old hagerstown Rd. | Months | Days | Hours | Min. | S. Date of Birth | Jan. | 19 | 38 | Solution | 19 | 38 | Sol 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 13 F 66 218-34-4075 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 10a. State 28a-f show the Medical Exacting must be notified at 1 Yes 2 No Middletown MD Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23e or USA 21769 9136 Old Hagerstown Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, it a Nuclical Fearmanning. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: White Specify þ 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) own home homemaker 8. Mother's Name (First, Middle, Maiden Sumame) Ruth Travis 17. Father's Name (First, Middle, Last)
George W. Summers (Brother) 9136 Old Hagerstown Rd., Middletown, MD 19a. Informant's Name/Relationship (Type, Print) Charles Summers 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State Harmony Cemetery 12/14/04 Myersville, 4 Donation 5 Other (Specify) 21. Signatur of Funeral Afvice Licens Bornard do Bss of Thrompson Funeral Home P. O. Box 18, Middletown, MD 21769 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence buy Disease Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗀 No certificate 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 2 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ Ño 2 ER/Outpatient 3□ DOA Medical Certification: To 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 2 🗌 No 1 Tes investigation death. Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pletely filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier The certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December, 13,2004 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Maha 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar 6

			State of Maryland / Department of Health and Mental Hygien 1- State of Maryland / Department of Health and Mental Hygien Certificate of Death	0001	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death	No.	3. Time of Death
	Physici /Medi		107 . 3 # 2 = 3	Day Year	0800M
	Examir		er 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death	
			University of Maryland Hospital Baltimore, MT	Beltimor	e City
	Funeral Director		5. Social Security Number 407-06-0682 6. Sex 1 Months Days Hours Min. (Month, Day, Ye	ear) Coul	place (State or Foreign ntry)
			Usual Residence of Decedent	62 Texa	ls
	how		10a. State 10b. County 10c. City, Town or Location	7	I0d. Inside City Limits
	88-1 s	Director	Maryland Frederick Frederick		1 ☐ Yes 🏋 No
	vith th	Dire	10e. Street and Number 10f. Zip Code 10g.	Citizen of What Cour	ntry?
	s 23s	eral	6624 Gooseander Court 21703	USA	
	ter de Itam	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1	14. Race - Americ Black, White,	
21215-0036	hours after death with the Maryland turel', or Itams 23a or 28s-f show at Examiner must be notified at	ğ	3 □ Widowed 4 □ Divorced If \$\tilde{Y}\ es ar or Dates: 1982 - 1986 1 □ Yes 2√2 No Specify:	Specify:	White
2-0	72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b	. Kind of Business/Inc	dustry
2	within ene.	nple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)		·
	e filed within al Hygiene. other than '		Telecommunications Specialist U		nment
and	ntai H ad oti	Be	Φ	len Sumame)	
Maryland	should be nd Mental markad c	스	Clayton Mullins Luzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City	Keilholz	
Ma	2 8 8 3		Angela Mullins/Wife 6624 Gooseander Court, Frederick		
ē,	s 1 and 2 f Health item 27 l		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c.	Location - City or To	
Baltimore,	permit. Pages Department of I Importent: If it any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		
alti	permit. Departm Importer any Inju		'4 □ Donation 5 □ Other (Specify) Glade Cemetery 12/19/2004 Wa 21. Signature of Funeral Service Accesses 22. Name and Address of Facility Stauffer Fun	ilkersvill	e, MD PΔ
m	Depa Impo any le		1621 Opossumtown Pike, Frede		
			23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.		Approximate Interval Between
	Pitysician		Immediate Cause (Final disease or condition a Greft V5 Host disease		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		/ munch
	Lxammer	L.	Sequentially list conditions, if any, leading to immediate b. TT thrombotic Thrombotist Purpur Due to (or as a consequence of):	(a)	Zweehs
	ted Tsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury		21
	al-trag	xan	C. Fungel Septicamic. Fungel Septicamic. Due to (or as a consequence of):		E dens
8760,	ficate be executed physician and s the burial-transit	dical	8		
9	tificat ng phy as th	edi	9		
ŏ	death certific	an/N	If FEMALE: 23b. Was decedent pregnant	23d. Date of deliver	ry
.O. Box	the att	sicia	in the past 12 months? I are the past 12 months	Month	Day Year
<u>Ч</u>	es that the death cer igned by the attendin be detached for use	Physician/Me	9 Unknown		
Records,	The law requires that the death certifite has been signed by the attending vage 2 should be detached for use as	l by		o use contribute to the	/
Ö	w requir been si should I	etec	1 Yes	2 No 3 Proba	ably 4 Munknown
Rec	has ge 2	Completed	24a. Was an autopsy performed?	prior to con	sy findings available apletion of cause of
	iician: The l				2 🗆 No
Division of Vital	ysician: is certific director,	To Be			
0	ding Phys h. After this funeral di)
jor	endin sath. or: Aft	atio	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
Σ	after death Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street a building, etc. (Specify)	and Number or Rural	Route Number,
	urs af urs af ural D				
	e Hospitel 124 hours a e Funeral l letely filled	edical	29a. Certifier (Check only one) 29 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(20 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	(s) and manner as stand place, and due to	ited. the cause(s)
	To the Hospitel or Attending Physician: within 24 hours after death or after this certification the Funeral Director; After this certification place of the funeral director, to the funeral director, the funeral director of the funeral director.	Med		Date signed (Month, D	
	r s ⊢ ŏ		1 8 60. MID AUUT/URS DISTSY 17	2/16/20	-,, , , , , ,
	,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1-1-1	
í	3		Mork Derho, MI) 10 5 Prochum 57 dog 3 Be	14 man. 1.	וודוך תו
	Sta	-	31. Date filed (Month, Day, Year) 32. Registra's Signature		1) 6.(7)
	Registra	ar	DEC 1 7 2004 Decree & Soule		

		·	State of Maryla	nd / Dep		lealth and	Mental Hy	giene	004	4168
Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) William F. Mart 4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, o			8 ,	2004 unty of Death	3. Time of Death 9:15a M
Funeral Director		211 Winchester 5. Social Security Number 213-36-4727 Usual Residence of Decedent		. last birthday		napolis If Under 24 Hr Hours Mir	s. 8. Date of Birt	h	nne Ar 9. Birthp Coun	ace (State or Foreign try) MD
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or liems 23a or 28a-f show other traumatic event, the Medical Evaring mast be notified at	rector	10a. State 10b. County MD Anne Art 10e. Street and Number		lity, Town or L		apolis		10g. Citizen	of What Coun	od. Inside City Limits 1 ☐ Yes 2 No
death with ns 23a or	Funeral Director	211 Winchester Bea	2. Was Decedent Ever in	U.S. 13.	Was Decedent of H				USA Race - Americ	an Indian,
hours after c	by	1 Never Married 2 Married 3 Widowed 4 Divorced	ILALIUS ZI INO	958	1 ☐ Yes 2 🔀 No	Specify:		Spe	BOITY.	hite
l within 72 h liene. r then "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) 5+	16a. Dece (Give life.	edent's Usual Occup e kind of work done DO NOT use retired Dentis		orking		of Business/Inc nistry	lustry
nd 2 should be filed lith and Mental Hyg 27 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) William F. Martin				Clara	spickna	11	,	
and 2 sho salth and n 27 is m		19a. Informant's Name/Relationship (Type Helen Jean Martin	/Wife	211	ing Address (Street Winchest	er Beac	h Drive,	Annap	olis, N	1D 21401
permit. Pages 1 and Department of Heali Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		osition (Name of matory or other place Cremator	y D∈	Date 2004		on - City or To imore,	
permit. Departr Importe any inji		21. Signature of Funeral Service License	2	I I	2. Name and Addre Barranco (195 Gov. 1	ss of Facility & Sons, Ritchie	P.A. Seve	erna P erna P	ark Fu ark, M	neral Home 21146
Physician attending physician and attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last		equence of):	MOIN	ny OP/	my			Interval Between Onset and Death
he death certificat the attending phy ched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy	,		23d.	Date of delive Month	ry Day Year
wrequires that the death	5	Part II. Other significant conditions con	tributing to death but not re	esulting in the	underlying cause giv	en in Part I.		obacco use d		e cause of death?
The lay	e Completed	25. Was case referred to medical				00 Pl (D	1 ☐ Yes	osy rmed? 2000No	4b. Were autop prior to con death? 1 \(\text{Yes} \)	osy findings available appletion of cause of
ng Phy Ifter this	To B	examiner?	ospital: 1 Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatie	of 28c. Injur Wor	er: 4 Nursing	eath (Check only on Home 5 sesion 28d. Describe h	dence 6 🗆)
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Tou	vn, State)		Route Number,
To the Hospitel or within 24 hours after To the Funeral Director Completely filled in	Medical	(Check only 2 Medical Exeminone)	ician: To the best of my ki er: On the basis of examinand manner stated.	nowledge, dea nation and/or in	nvestigation, in my o	pinion, death occ	curred at the time, o	date and pla	ce, and due to	the cause(s)
with To 1	Σ	29b. Signature and title of certifier	= MD		29c. Licens				gned (Month, I	
St Regist	ate	30. Name and address of person who construction of the constructio	Pegistrar's Sign	em 23a) (Type	Print) Drowso	: Huy	tyon, A	NNM	240	2140/

			For State Registrar	State of Ma	aryland		artment rtificate			and M	ental Hy	giene	004	416	83
	Physicia		Decedent's Name (First, Middle, L. William McKend								2. Date of De Dec.	eath Day	2004	3. Time of De 7:15	
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)			4b. City, To	own, or L	ocation o	of Death			nty of Death		
			25 Clara Circl						n Bu				nne Ar	undel	
	Funeral Director		176-26-1798	Sex 7. Age 1⊠M 2□F	69 (In yrs. la	ast birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Bil (Month, D) Dec.	14,1934	9. Birthp Cour	lace (State or F	oreign
	/land	Ì	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					-	1	0d. Inside City I	Limits
	e Mar	ctor	MD Anne	Arundel			C	Glen	Burr	nie				1 ☐ Yes 2	₩ No
	vith th	Dire	10e. Street and Number	1 -			10f. Zip C					10g. Citizen o		itry?	
	eath v	eral	25 Clara Circ	12. Was Decedent I	Ever in U.S	13 1	Was Decede		1060	nin? (Sne	cify Ves or No	D 14 B	USA ace - Americ	an Indian	
036	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or terms 23a or 28a-f show event, I'ra Madical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		'	f Yes, specif		Mexican Specify:	, Puerto F	cify Yes or No Rican, etc.)		lack, White, city: Whi	etc.	
5-0	72 ho 'natur	eted	15. Decedent's (Specify only highest of			(Give	dent's Usual kind of work	done du	ion ring mosi	t of workin	ıg	16b. Kind of	Business/Inc	dustry	
21215-0036	within ene. than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo not use Machir					Mic	ero Mac	chinery	
ᅙ	a filed Il Hygi other	Be Co	17. Father's Name (First, Middle, La	st)	1			1	18. Mothe	er's Name	(First, Middle	, Maiden Sum			
ylar	should be filed withir nd Mental Hygiene. marked other than imatic event, the M	ToB	Flavius McKendr	ick					Virg	jinia	A. Mc	Kenrick			
Maryland	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship Barbara McKendr									oer, City or Tou		Code)	
e,	Healt Healt tem 2		20a. Method of Disposition	ICK/ WITE	20b. Pla	ace of Dispo				Dec.	Burnie	20c. Locatio	21060 n - City or To	wn, State	
E O	Pages nent of nt: If i		1 Surial 2 □ Cremation 3 14 □ Donation 5 □ Other (Special Control of the Control		I -	en Hav					004	Glen	Burnie	e, MD	
Baltimore,	permit. Pages 1 end 2 should be Department of Health and Menla Important: If item 27 Is marked any injury or other traumatic ex		21. Signat Te of Funeral Service Lic	ensee		B A	Name and arrance	Address O &	of Facilit Sons tchi	, P.	A. Sev	erna Pa erna Pa	ırk Fui	neral Ho 21146	ome 6
			23a. Part I Enter the disease, or co	mplications that caused ly one pause on each lin	the death	Do not ent	er the mode	of dying,	such as	cardiac or	respiratory a	irrest,		Approximate Interval Between	en
	Pnysician		Immediate Cause (Final disease or condition	meta	1 1				1		MCE		=	Onset and Dea	ath
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):									
	1.0	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):								-	
	nd ransit	Examiner	that initiated events	c.											
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	ence of):									
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Records,	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death of	ut not resu	iting in the ui	nderlying cal	nse given	in Parti.		1 🗆	1-1		e cause of deat	
l Rec	The ate had page	Completed									24a. Was auto perfo		prior to cor death?	osy findings ava npletion of caus 2 No	ulable se of
Vital	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	11						of Death	(Check only				
of	Physic r this c rat dir	- T	1 ☐ Yes 25 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		R/Outpatien 28b. Time of			4 🗀 19u			idence 6 C)	
on	Attending Physician: r death. sctor: After this certificiny the funeral director.	tlon	1 Natural 5 Pending 2 Accident investigat	(Month, Day	Year)	Injury	M	c. Injury a Work? 1 🔲 Ye	n es 2 🗆 l		00. 00301100	now injury occ	unou		
Division	I or Attend after death Director: A I in by the f	Certification:	3 Suicide 6 Could not		ury - At hor c. (Specify)	n <i>e</i> , farm, str	eet, factory,	office		2	8f. Location (City or To		nber or Aura	Route Number	r.
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Description	Physician: To the best on the basis of aminer: On the basis of and manner sta	examinati	vieage, death on and/or inv	occurred at vestigation, in	tne time n my opir	nion, deal	a piace, a th occurre	nd due to the d at the time,	date and place	nanner as st e, and due to	ated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier					Licens <i>e</i> i			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	29d. Date sign		Day, Year)	
			L'OU	1				35	325	P	1	12-13	-04		
			30. Name and address of person wh		eath (Item	23а) (Туре,	Print)	MA		2	1220	3			
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signati	ure	<u> </u>	. V V	- Trix)			
	Registr	ar	DEC 1 5 20	104 John	, B.	1900									

MAN			1 - State Unpend Item	State of M 23a&27 pe	aryland/f r me G83	Depar 39 <u>F</u>	tment ificate	of Hotas	ealth a	and Men	tal Hyg	iene	14 1/1681
			Decedent's Name (First, Middle, Las.							2. [Date of Deat	th	3. Time of Death
	Physici /Medio		Pamela Ann McKoy							_	Month Cember		Year 1004 1739 P M
	Examir		4a. Facility Name (If not institution, give			4	4b. City, To			of Death		4c. County o	
			Washington County			and be referred to	Hage If Under 1		If Under	24 Hrs 0 r	2-1(B)-4	Washin	
5	Funeral Director		5. Social Security Number 6. Sec. 197-52-3080	X	ge (In yrs. last bir 36			Days	Hours	Min. (Date of Birth Month, Day, t 17,	Year)	9. Birthplace (State or Foreign Country) [arvland
7	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow		Ni-					2,00	
	death with the Maryland ms 23a or 28e-f show	5					ulon						10d. Inside City Limits 1X Yes 2 □ No
	the M 28e-f	Directo	Maryland Washingto 10e. Street and Number	n	Hagerst	town	10f. Zip C	ode			1	0g. Citizen of Wh	
	th with 23a or		205 East Hillcres	t Pond			2174					.S.A.	,
	ter deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. Wa	as Deceder	nt of His	spanic Orig	gin? (Specify , Puerto Rica	Yes or No-	14. Race	- American Indian,
98	ours after death with the Maryla el', or Items 23a or 28e-f shor Examinar must be rollfied at		1 Never Married 2 X Married	1 ☐ Yes 2X		1	Yes 2			i, ruello Alca	11, 810.)	Specify:	, White, etc.
5-0036	naturel',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:	100		nt's Usual						White
15	filed within 72 hours after Hygiene. ither then "naturel", or Ite ont, the Medical Examina	Completed	(Specify only highest grad	de completed)		(Give kir life. DC	nd of work NOT use	done di retired)	uring most	t of working		16b. Kind of Bus	iness/industry
212	d with giene er the	E O	Elementary/Secondary (0-12)	College (1-4or 2		ау Са	re Pi	covi	der			Day Car	e
pu	0 7 0 ×	Be (17. Father's Name (First, Middle, Last)								7.5	Maiden Sumame,)
yla	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Mental Hygiene.	ပု	Robert Allen Sell							ce Mar			
Maryland 2121	es 1 and 2 should b of Health and Ment fitem 27 is marked r other treumatic e		19a. Informant's Name/Relationship (7									City or Town, S	
<u>ə</u>	Heali Heali tem 2 other	1	Brett DeVon McKoy 20a. Method of Disposition	/ Husban	20b. Place of	f Dispositi	ion (Name	of	-	d Hage:		MD 217- 20c. Location - C	42 lity or Town, State
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Rest Ha	-	tory or oth			2/10/2			
alti	permit. Pag Department Importent: any injury once.	1	21. Signature of Funeral Service Licens		Kest na	22. 1	Vame and	Addres	s of Facility	Z/IO/Z ^y Rest	Haven	Funeral	own, Maryland Chanel
ä	Depar Impor any ir		In to 12	~	^								Maryland 21742
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a ASTHMA	d the death. Do noted that the death. Do noted		the mode	of dying	, such as	cardiac or res	piratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	<u>.</u>	Sequentially list conditions,	b	a consequence	of\:							
	ned	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D00 t0 (0) as	a consequence	01).							- 54
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	Ical Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence	of):		<u> </u>					
9	eath certifica attending pl	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy							23d. Date	of delivery
P.O. Box	it the death by the atter tached for u	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Dunknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death t time of death		ctopic preg Other (spec					Month	
rds, P	requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death t	out not resulting in	n the unde	erlying cau	se give	n in Part I.				ute to the cause of death?
Vital Records,		Completed									24a. Was ar autops perform	y prid ned? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 \sum No
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		965					of Death (Ch			
of \	Physi this c	2	1√ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati		tpatient Time of	3□ DOA	Othe	r: 4 🗆 Nur			nce 6 Other	
Division of	ding h h. After funer	tlon	1X Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	lnjury Work 1 □ Y	at ? 'es 2 □ N		Describe no	w injury occurred	
/isi	Attendi death. ctor: A	flca	3 Suicide 6 Could not be	28e. Place of In	jury - At home, fa tc. (Specify)	arm, street				28f. L	ocation (Str	reet and Number	or Rural Route Number,
D.	el or safter of in bid in b	Certification:	4 Homicide	building, e	tc. (Specify)					(City or Town	, State)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely illed in by the funeral director.	edical (29a. Certifier (Check only one)	rsician: To the best iner: On the basis of and manner st	of examination an	e, death or id/or inves	occurred at stigation, in	the time my opi	e, date and inion, deat	d place, and o	due to the ca the time, da	use(s) and manrate and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	mid					number		29	d. Date signed (Month, Day, Year)
			I him his	, MIO				0.C	.M.E.		D	ecember	14, 2004
			30. Name and address of person who c	ompleted cause of a	death (Item 23a)	(Type, Pri	111 F	enn	Stre	eet, Ba	ltimo	re, Mary	land 21201
	Sta Registi	_	31. Date filed (Month, Day, Year) JAN 0 3 2		rar's Signature	Soc	uli						

			For State Registrar	State of N	Maryland		artment rtificate			and M	-	gien Reg. N	2001	41685
	Physici /Medic		Decedent's Name (First, Middle, the Harlan David Network)								2. Date of De Month	Da	ay Year 15 2604	3. Time of Death 9
	Examin		4a. Facility Name (If not institution, g Washington Count		Ť				Location of				c. County of Death Vashingto	
	Funeral Director		5. Social Security Number 6. 465–70–3960	Sex 7./ 10XM 2□F	Age (In yrs. I	ast birthday) 9 Yrs.	If Under Months	Jers Year Days	Hours	Min.	8. Date of Bir (Month, Da	th ay, Year	9. Birth Cou	place (State or Foreign intry)
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	h the Mar	Director	Maryland Washir	ngton		Hage	erstov 101. Zip					10g. C	itizen of What Cou	1 Tes 2 No untry?
	th wit	a D	13517 Spring Hi	ll Drive					21	742			U.S.A.	
9800	4 within 72 hours after death with the Maryland Jene. I than "naturel", or Items 23e or 28e-f show The Medical Examiliar man be incillised at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? X No		Was Deced If Yes, spec 1 Yes 2		spanic Origin, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.))-	14. Race - Ameri Black, White Specify: Whi	, etc.
21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	College (1-4c	or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired)	ition <i>Juri</i> n <i>g most</i>)	t of workin	g		Kind of Business/Ir	,
121	filed w Hygier other th		17. Father's Name (First, Middle, La	2		Wr	ter		18 Mothe	ar's Name	(First, Middle	S. Maide	elf Emplo	oyed
and	ed at a	То Ве	Werner A. Newho								a House		03	
Maryland	should and Men Is marke	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a					or Town, State, Zi	ip Code)
Baltimore, M	ges 1 and 3 of Health If Item 27 or other tra		Louise Mary New 20a. Method of Disposition 1 R Burial 2 Cremation 3	☐Removal from Sta	20b. Pt	tace of Dispo emetery, crei	sition (Nam natory or ot	ne of ther place	9)	Di	ate	20c. L	Location - City or T	
Itim	Dermit. Pag Department mportant: any injury once.		* 4 Donation 5 Dother (Special Signature of Funeral Service Lice		GI	eenhi]				12/17				Pennsylvani
Ba	permit. I Departm Importa any inju		1 L (James)	o Paul	ees J	7	331 E	aste	ern B	lvd.	N. Hac	iers	town Mar	eral Home yland 21742
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O. Box 6	that the death certifical hed by the attending phi detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal at time of de	death 3	Ectopic pre Other (spe						23d. Date of deliv Month	rery Day Year
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Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	AP.		(Check only o			
of	ding Phys n. After this funeral dir	ation: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Ir (Month, L		ER/Outpatier 28b. Time o Injury		Bc. Injury Work	4 🗆 Nu	2	ne 5 Residente R		6 ⊡Other (Specia ury occurred	fy)
Division	i Sign	Certification;	3 ☐ Suicide 6 ☐ Could not determine	280. Place of	Injury - At ho etc. (Specify		eet, factory	, office		2	8f. Location (: City or Tox	Street ar wn, Stat	nd Number or Rura re)	al Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the be aminer: On the basis and manner	of examinat	wiedge, deatl ion and/or in	occurred a	at the tim in my op	e, date and inion, deat	d place, at th occurre	nd due to the d at the time,	cause(s date an	s) and manner as s nd place, and due t	stated. o the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier	1	XI	-\	29c.	. License	number	7 -		29d. Da	ate signed (Month,	Day, Year)
)	1		1007	2 to	5/ 0			000	Dle 5	15		16	Dec C	7
5	(t)		30. Name and address of person who	1110	Medi	cal	Print)	XLS	Rd	Has	ersto	WN	MD :	21742
	Sta Registr		31. Date filed (Month, Day, Year)	2004	strar's Signat	iure	rende	,			J			-

amend item#1, permd, C839, 1/28/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Asencia Pacheco Osco 2. Date of Death 3. Time of Death **Physician** Day Month Pacheco Ageencia 0sco9:30 рм 12-10-2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F 577-08-5378 Yrs. Director 54 05-18-1950 Peru Usual Residence of Decedent death with the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28e-f show ultrar must be notified at Director 1 Yes 2 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14902 - C McKisson Court 20906 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, .. Pages 1 and 2 should be filed within 72 hours after tment of Health and Mental Hygiene. Tant: If item 27 is marked other then "naturel; or ite Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2□No Specify: Peruvian Specify: White the Medical Exam Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Nanny Self-Employed other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leon R. Pacheco Bernaola Sebastiana Osco Mendoza ဂ္ 19a. Informant's Name/Relationship *(Type, Print)*Juana Alipia Pacheco Osco/sister 19b. Mailing Address (Street and Number or Rural Route Number City of Town State, Zip Code) Manzana H Lote 18 Grupo 26 VIIIa El Salvador Lima, Peru 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 12-18-04 Lima, Peru permit.
Departn
imports
eny inju 22. Name and Address of Facility W. H. Bacon Funeral Home, 21. Signature of Funeral Service License 3447 14th Street, N.W. Wash., D.C. 20010 landa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Anemia 2₹ No 3 Probably 4 Unknown Completed Sepsis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? Yes 20 No 1 🗌 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 🕅 Natural 5 Pending 2 Accident investigation 1 Yes 2 No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerei [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) Kshama D60826 12-10-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road

DHMH 17 Rev 1/2001

State Registrar Kshama Garg, MD

DEC 1 3 2004

31. Date filed (Month, Day, Year)

Registrar's Signature

Silver Spring, Md..

20910

				1 _ State	tate of Maryla	nd / Depa			ental Hygier	0001	
				Registrar 1. Decedent's Name (First, Middle, Last)		001	incate of L		Reg. 2. Date of Death	NOT UU	- 4-L-6-8-7
		Physici	an		ANNA OKOR	0		-	Month	Day Year	3. Time of Death
4		/Medio		4a. Facility Name (If not institution, give street			4b City Town or	Location of Death	December	4c. County of Dea	
		Examir	ner								
		Funeral	-	Shady Grove Advers 5. Social Security Number 6. Sex	ntist Hos 7. Age (In yrs	pital (: last birthday)	Rockvi If Under 1 Year		B. Date of Birth (Month, Day, Ye	Montgon 9. Bir	
		Funeral Director			2√2 F	Yrs.	Months Days		(Month, Day, Ye		thplace (State or Foreign ountry)
		ס		Usual Residence of Decedent				10	00,20,2	004 1 146	ryland
		rylar thow	_	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
		Be-f.	ct	MD Montgome	ery	Silv	er SPri	ng			1 XYes 2 □ No
		or 2	Dire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
_		s 23e	rai	13009 Autumn Driv			2090			U.S.A.	
Q		er de	nu.		Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 XNo	0.8.	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R	rry Yes or No- ican, etc.)	14. Race - Am Black, Whi	
ď	36	rs af	by Funeral Director		If Yes, Give Year or Dates:		☐ Yes 2X No	Specify:		Specify: E	Black
X	21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show te Madical Examiner must be nutified at	ted	15. Decedent's Education	on	16a. Deced	lent's Usual Occupa	ution	16b	. Kind of Business	/Industry
3	215	hin 7.	ple	(Specify only highest grade co	ompleted) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	luring most of working)	7		
す	21	d with	ě	Ó		No	ne			None	
FosterakoR	pu	al Hy al Hy d oth	Be Completed	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maid	len Sumame)	
_	Va Va	Ment Ment arked aric e	2	Lambert Okoro				Bever	ly Fost	er	
3aby	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-1 show any injury ocother traumatic evant, It's Madical Examiner must be notified at once.	88 -	19a. Informant's Name/Relationship (Type,	•			nd Number or Rural		-	
Ša	-	l and fealth im 27 her t		Lambert Okoro- Fa				n Dr Sil			
0.	Baltimore	ges H of H		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remo	oval Ilolli State		sition (Name of natory or other place	I		Location - City or	
	ŧΪ	t. Partmer		'4 □Donation 5 □ Other (Specify)	G		Heaven				pring, MD
	Bal	Deparmine Department of the procession of the pr		21. 9Ignature of Funeral Service Licensee	Vincelle			s of Facility Sno			
			_	23a. Part 1. Enter the disease, or complication	ons that caused the dea					kville,	MD 20850 Approximate
		L		shock, or heart failure. List only one commediate Cause (Final	ause on each line.	aut. Do not one	or the mode of dying	g, saon as caralao or	respiratory arrest,		Interval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)	Due to (or asia conse	5					ahus
		Examiner			C - L-c	, , .	0 1	1.			0 da =
			ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):	remati	25,40			DUAYS
		uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events)
	oʻ	te be executed ysician and te burial-transii		resulting in death) Last	Due to (or as a conse	quence of):					
	Box 68760,		ical	d							
	99	n certifica anding ph use as th	Med	IF FEMALE:						1	
	30	eath certif attending for use as	an/l	23b. Was decedent pregnant 23c.	If yes, outcome of pregr 1☐Live birth 2☐Fet		Ectopic pregnancy			23d. Date of de Month	ivery Day Year
	O.E	ne dea the at	sici		4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)			WOTHER	Day 18ai
	P.O.	es that the de igned by the be detached	by Physician/Med	Part II. Other significant conditions contrib	uting to death but not re	eulting in the ur	Iderbing cause give	n in Part I	23e Did tobaco	o use contribute to	the cause of death?
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	Ö	w requir been s should	etec								,
	Rec	has ge 2	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
	a	ician: Th		25. Was case referred to medical					1 ☐ Yes 2		2No
	Ξ	sicia certi	o Be	examiner? 1 Yes 2 No	oital: 1 ☑ Inpatient 2 [☐ ER/Outpatien	t 3 DOA Othe	26. Place of Death (S ☐ Residence	6 DOthor (Con	
	of	ding Physician: The n. After this certificate ha funeral director, page	n; To	27. Manner of Death 2	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		d. Describe how in		ciry)
	ion	uttanding F death. ctor: After y the funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		? ′es 2 □ No			
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	Ö	tal or rs afte al Dir	Certification;		building, etc. (Opec	uy)		l)	Only or rount, on	4107	56
		To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical	29a. Certifier (Check only one) 1 Certifying Physicis 2 Medical Examiner:	an: To the best of my kn On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tim restigation, in my op	e, date and place, an inion, death occurred	d due to the cause at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
_		withir To th	Me	29b. Signature and title of certifier			29c. License			Date signed (Mont	*
				1 Il alm	UMD		Do	585	/	2/5/0	4
				30. Name and address of person who compl	leted cause of death (Ite	em 23a) (Type,	Print)	ρ	ockwille,	MD 208	30
	-			Heather Cahon,	4D. Sho	dy Gro	se Medic	1585 cal Cente	R 9901	Medical (extr Drile
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			1 - For State Registrar	State of I	Marylar		artmen rtificate			and Me		giene Reg. No. 2 (004	4168	3 8
	Physic /Medi		1. Decedent's Name <i>(First, Middl</i> e, l B ryan]	_{ast)} Michael PA	ARKS					-	2. Date of Dea Month	Day	Year	3. Time of Death	M
	Examir		4a. Facility Name (If not institution, g	ive street and numb	er)		4b. City,	Town, or	Location of			4c. County			
			Washington Coun				-	erst				Washi	ingto	n	
	Funeral Director		299-82-4611	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs.	35 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day (arch I	2,1969	9. Birthp Cour Mary	elace (State or Foreig stry) 11and	חק
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	eation						1	0d. Inside City Limit:	S
	Maryl f sho	tor	Maryland Washin	gton	Н	agerst	own							1 ☐ Yes 2,☐ (N	
	h the or 28e	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of V	What Cour	itry?	
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21215-0036	d within 72 hours after death with the Maryland Jione. Ir than "naturel", or Items 23e or 28e-f show The Medical Evantrer must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? No	1	Was Deced f Yes, spec 1 ☐ Yes 2			gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	14. Rac Blac Specify	e - Americ ck, White, v: Wh		
2-0	72 ho natur	eted	15. Decedent's (Specify only highest of			16a. Deced	dent's Usua	i Occupa	ation Jurina most	of working	7	16b. Kind of Bu	usiness/Ind	dustry	
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		kind of wor DO NOT us	e retired)	01 ***					
	filed v Hygie other t		0-12 17. Father's Name (First, Middle, La.	0		plu	mber		18 Mothe	r's Namo /	Eirst Middle	plumbi Maiden Sumam		0.	_
Maryland	be do do	To Be	Joseph .	A. Parks,	III						Carole	e Gossar	d		
Mai	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship Joseph A. Parks		thar	4.5						r, City or Town, Ohio 4		Code)	
	1 and Healt tem 2		20a. Method of Disposition	, 111 - 16	20b. F	Place of Dispo	sition (Nam	ie of	1	Da		20c. Location -		wn State	
Baltimore	9 = 5		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te C	emetery, cren	natory or ot	her plac	10	ecemb	er				
븊	in the state of		21. Signature of Funeral Service Lic		на	gersto	. Name and					Funeral		laryland e	
B	permit. Deports Imports any inj		Fred L. Vest	al							., Hage	erstown,	Mar	yland 217	40
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	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions AIDS D	contributing to death	but not resi	8	nderlying ca	iuse give	n in Part I.			h.		e cause of death?	1
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ξ	Physicien: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:				Othe	~		Check only on				
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Divis	al or Atte s after de l Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of	Injury - At ho etc. <i>(Specif</i>)	ome, farm, stre	eet, factory,	office		28	f. Location (St City or Town	reet and Numbe n, State)	er or Rural	Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) Certifying F Certifying F	hysician: To the beaminer: On the basis and manner	or examinal	wledge, death tion and/or inv	occurred a restigation,	in my op	inion, deat	h occurred	at the time, d	ate and place, a	ind due to	the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	6-1			29c	License	number	.0-	2	9d. Date signed	(Month, E	Dey, Year)	
)			MACash	1770			_	0	35	17,	/	12-	-18	-04	
h	4-4		30. Name and address of person who	completed cause o	f death (Item	23a) (Туре, I	Print) // 2	2	OPA	41	CT. H	LAGER	STOR	2 (74)	
	Sta Registr	111	31. Date filed (Month, Day, Year)	2004	strar's Signa	ture	menta.	g						2174	

			1 - For State Registrar	State of Ma	ryland	•	rtmen			and M		iene •g. No.20	04	41689
	Dhuria!		1. Decedent's Name (First, Middle, La								2. Date of Deat Month		Year	3. Time of Death
	Physici /Medic		Julia Catherine 1	PRICE		- · · · · ·					December	r 20, 2	004	12:05 a.™
	Examin	er	4a. Facility Name (If not institution, give			_			Location of	of Death		4c. County		
		7_	Beverly Healthcan 5. Social Security Number 6.8			n st birthday)	Hage If Under	1 Year	OWN If Under:	24 Hrs.	8. Date of Birth	Wash		
	Funeral Director			□M 2025F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, July 2,	Year) 1921		nplace (State or Foreign untry) .ryland
	iand iand		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
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	or 284	Jirec	10e. Street and Number				10f. Zip				1	0g. Citizen of V	Vhat Col	untry?
	ath wi	rai	Bittersweet Drive						L740				SA	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28a-f ehow entry injury or other traumatic event, the Medical Examination and Le notified at ORGe.	by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		j	Vas Deced fYes, spec I□Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		k, White	ican Indian, o, etc. 'hite
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lar.	2 sho		19a. Informant's Name/Relationship (•			_				I Route Number,	_		
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<u>_</u>	nysica nis ca direc	ToB	examiner? 1 □ Yes 2 No	Hospital: 1 Inpatier	nt 2 🗆 El	R/Outpatient	3 □ DO	A Othe	" 4 Nu	rsing Hor	ne 5 🗆 Reside	nce 6 Othe	er (Speci	ify)
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5	H-1		MANZAN.	Completed cause of de	ath (Item 2	23a) (Type, 1	Print)	tru	1-1-	lagi	Horun	MOZIT	190.	
	Sta Registr		31. Date filed (Month Par Year) 2	2004 32. Registra	r's Signatu	re F	rester				ed at the time, da			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Year 06 04 3:25A.M. Ε. Powell Ruby 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) ${ t Burtonsville}$ Montgomery Holy Cross Nursing Home | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 07 01 10 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 □ M 2 X F 94 Yrs. Elberton, GA. 578-42-0359 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Silver Spring Montgomery 1⊠ Yes 2 □ No 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20910 USA 8715 1st. Avenue Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Currency Examiner 2 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Elizabeth Hunter John Rucker 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16409 Eves Court Bowie, MD. 20716 Gary R. Powell/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 □ Cremation 3 □ Removal from State 12-10-04 Suitland, MD. Lincoln Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MArshall's Funeral Home 4217 9th. St. N.W. Washington, D.C. 20011 23a. Perty. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimers Disectore Due to (or es a consequence of) Due to (or as e consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditione contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☒ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death?

Physician /Medical Examiner or Attanding Physician: The law raquiras that the death certificete be executed

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

Funeral

Director

death with the Marylend

Pagas 1 end 2 should be filed within 72 hours after death with the Marylen nant of Health end Mentel Hygiene. ant: If Itam 27 is marked other than "naturel, or Itams 23a or 28a-f show ury or other traumatic event, the Medical Evantina must be notified at

permit. Pagas 1 end 2 Depertment of Health e Important: If Itam 27 is any Injury or other tra

Baltimore, Maryland 21215-0020

tor: After this cartificate has been signed by the ettending physician and the funerel director, page 2 should be datached for use es the burial-trensit deeth.

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical ð Completed Be Certification: To To the Hospital or Attendition 24 hours after death, within 24 hours after death.

To the Funeral Director: A completely filled in by tha fi Medical

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Mennet of Death 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 29b. Signature and title of certifier marie

DEC 1 (Manth 1990, 1/19 ear)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Yeer) D 25348 604 almai MD 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 3415 Greencastle Rd. Burtonsville, MD. 20910 Marcia Goldmark, MD.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

2 Nu

1 ☐ Yes 2 ☐ No

State Registrar

8

DHMH 16 Rev 6/95

32. Redistrer's 20

28b. Time of Injury

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middla, Last) 3. Time of Death Day Year **Physician** Esther Peters December 4, 2004 12:40 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Montgomery Manor Care If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yaer) Funeral Days Hours 1 □ M 2 🗓 F 92 Yrs. El Salvador Nov. 30, 1912 Director 182-24-3035
Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or items 23s or 28s-f show ury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 Democracy Blvd. 20817 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 A No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Spacify: White Completed by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumama) Be Lola Duran Augustine Brizuela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 9514 Singleton Drive, Bethesda MD <u>Annabell Poms</u>, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If its any injury or of pace. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12-10-04 Alexandria, VA Mt. Comfort Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W., WDC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Examiner Due to (or as a consequence of): Physician/Medical Examiner Sepsis certificate has been signed by the ettending physician and irector, page 2 should be deteched for use as the burial-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Hypothyroidism Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in death) Last Hypertension Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Dementia ģ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? 1 Yes 3 No 1 ☐ Yes 2½ No within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 ☑ No Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Yaar) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1X Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ţ 29c. License number 29d. Date signed (Month, Day, Yaar) 29b. Signature and title of certifier D-20274 December 4, 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bethesda, MD 20817 Kirti Vohra, M.D. 7710 Bradley Blvd., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 13 2004 Darka Registrar

		1 - For State Registrar	State of Marylan		artment <i>tificate</i>			nd Me		jiene _{eg. No} .	11114		692
Physicia	an	Decedent's Name (First, Middle, Las.	t)						2. Date of Dea Month	Day	Year	3. Time o	
/Medic	al	Urna Mae Poole 4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of		ecember		County of Deat		a.m.
LAdimii	Ci	Avalon Manor Heal			Hage	ersto	own			W	ashingt	on	
Funeral Director		5. Social Security Number 6. Se 217-48-0244	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 10ril 2.	Year)	9. Birth Col. 911 Mar	nplace (State untry)	or Foreign
		Usual Residence of Decedent							priz 2.	- , <u>-</u>	JIH HUL		20. 11. 11.
Aaryian f show	ō	10a. State 10b. County Maryland Washin		y, Town or Lo Hageı	cation Stown	1						10d. Inside C	s 2 No
the h	Director	10e. Street and Number			10f. Zip (Code			1	0g. Citiz	zen of What Co	untry?	
th with 23e or 1st be	ai Di	18349 Woodside Dr	ive		217	40				U.	S.A.		
ified within 72 hours after death with the Maryland Hygiene. Hygiene. In the maturel, or Items 23e or 28e-f show ant, Ite Maryled Examiner must be notified.	by Funerai	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 247 No If Yes, Give Year or Dates:		Was Decede f Yes, speci l ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)		14. Race - Amer Black, White Specify:		
72 hours "naturel",		15. Decedent's Ed (Specify only highest grad	ucation	16a. Decec	lent's Usual	Occupa	tion	of workin	a	16b. Kir	nd of Business/l	ndustry	
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work			OF WORKING	9		tgomery		-
ified w Hygier ther th	S	17. Father's Name (First, Middle, Last)	4	Medic	al Se		-	's Name	(First, Middle, I		1th Dep	artmen	t
4 t 2 t 2	To Be	Thomas Clinton P	oole						tze1		,		
2 should and Men is marke		19a. Informant's Name/Relationship (7		1	•	•					Town, State, Z		
1 and 1 Health Health 27 other tr		Linda Price - gre 20a. Method of Disposition	at niece	lace of Dispo				7е, н Da			Maryla cation - City or		40
Pages nent of I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	nemoval nom state	_{emetery, cren} :haven				2-16-			erick,		nd
permit. P Departme Importer eny injur		21. Signature of Funeral Service Licens			. Name and						ral Hom		IIG
8958		eskarow Came	lle Gline								ck, Mar		
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to for as a consequence of the death	due	Heav	of dying	Fac	eardiac or Ein yn	espiratory arr	est, 		Approxima Interval Be Onset and	tween Death
be executed sician and burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)		line	<u> </u>						104	2
the age	dicai		d										
The law requires that the death certific are has been signed by the attending page 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3 □]Ectopic pre] Other (spe			_		2	23d. Date of deli Month	- ,	Year
uires that the de signed by the a		Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	bacco us	se contribute to	the cause of	death?
v requires been sign should be	ed by		·						1 □ Ye	es 2[□No 3□Pro	bably 4	Onknown
The law requate has been page 2 shouk	Completed								24a. Was a autops perform	y	death?	topsy findings ompletion of a 2 No	available cause of
icien: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe			(Check only on				
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nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	М		? 'es 2 ☐ N	io					
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stro	eet, factory,	office		28	Bf. Location (St City or Town	reet and n, State)	d Number or Ru	ral Route Num	nber,
Hospi 24 hour Funer stely fill	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysicien: To the best of my kno iiner: On the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred a vestigation,	it the time in my opi	e, date and inion, death	l place, ar n occurre	nd due to the ca d at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(:	s)
To the within To the comple	Me	29b. Signature and title of certifier			29c.	License	number		2	9d. Date	e signed (Month	Day, Year)	
		023				Ĭ.	52	32	-3	12	2/13/1	1	
1		30. Name and address of person who of Khalid M. Waseem	, M.D. 1941	4 Leit		rg P	ike,	Hage	rstown,	Maı	ryland 2	21742	
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrat's Signa	ture	Local	63 9							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) Month **Physician** Stanley John Prendki 10, 2004 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2015 Valley Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 26, 1918 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1(**X**M 2□ F 86 107-05-3205 Director New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examiner must be nutilised at Maryland Anne Arundel Annapolis 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2015 Valley Road 21401 U.S.A. or Items 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give 147.7 TT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o filed within 72 hours after de l'Hygiene. Other than "natural", or Item Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ If Yes, Give Year or Dates: WW II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Supervisor U.S. Government 12 other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is marked othe any injury or other treumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sebastian Predki Katarzyna Motyka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean Prendki/wife 2015 Valley Road Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | 12/14/2004 | Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home uneral Se 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Priysician one month ung Cancer disease or condition resulting in death) /Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 No Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical 26 Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Sescribe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 2 🔲 No 1 Tyes 2 Accident investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie lliar December 13, 2004 D29193 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edgewater, MD 21037 Stephen Killian, MD 3169 Brayerton St #201 : 31. Date filed (Month, Day, Year) 32. Re State DEC 13 2004 Registrar

			1 - For State Registrar	State of Ma	-		t of H	ealth a		, ,	iene	04	1.1601
	Physici		Decedent's Name (First, Middle, Last) Jacqueline N. Pa	rris						2. Date of Death Dec.	_	2004	3. Time of earl 10:40 p M
	/Medio Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City,	Town, or	Location o	of Death		4c. County	of Death	
			Genesis ElderCar	e			Sev	erna				ne Ar	undel
	Funeral Director		5. Social Security Number 6. Sex 1 6. S	7. Age	(In yrs. last birthda 77 Yrs.	y) If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 29,	^{Year)} 1927	9. Birthp Coun	place (State or Foreign htry) MS
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						1	Od. Inside City Limits
	8e-f sh	Director	MD Anne Ar	undel				erna I	Park				1 ☐ Yes 2 🙀 No
	with the	Dire	10e. Street and Number	_		10f. Zip				10	g. Citizen of 1		try?
	s 234	erai	24 Truckhouse Ro	ad 12. Was Decedent E	vor in II S 1	Was Dood		21146	ain? /Sno	city Voc or No-	14 Bac	USA e - Americ	ean Indian
336	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Medical Examana Lust be modified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 V If Yes, Give Year or Dates:	0	If Yes, spec		Specify:	i, Puerto i	cify Yes or No- Rican, etc.)		ck, White,	
2-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade		16a. Dec (Gi	edent's Usua ve kind of wor . DO NOT us	l Occupa k done d	ition Juring most	t of working	ng	6b. Kind of B	usiness/Inc	dustry
2121	d within giene. r then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	-) life	Homem					Hor	me	
Maryland 21215-0036	ould be filed Mental Hygin arkad other attc evant,	To Be C	17. Father's Name (First, Middle, Last) John R. Nevers							(First, Middle, M Harper	faiden Suman	ne)	
Mary	d 2 should th and Mer 7 le marks treumatic		19a. Informant's Name/Relationship (Ty) William Parris/Hu		19b. Ma					Route Number, 7e, Seve			
	1 and Healt em 2 ther		20a. Method of Disposition		20b. Place of Dis		e of	1	D	ate 2	Oc. Location -		
Baltimore,	Page ent c nt: If ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	MD Vete	rans Ce	emete	ery		004	Crowns		
Ba	permit. Departm Importa any inju		21. Signature of uneral Service License	lh		Barran 495 Go	v. R	Sons	š, P. ie Hv	A. Seve	rna Pai rna Pai	rk Fu rk, M	neral Home D 21146
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line	the death. Do not e.e. Agg. consequence of):	a						1	Approximate Interval Between Poset and Death
68760,		ical Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	77.	the	in	er.	is der	neni	14	gears
.O. Box	death certifica e attending ph id for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 10 □ Unknown	Fetal death	B□Ectopic pre			-0.40			te of delive	ry Day Year
rds, P	sign d be	by	Part II. Other significant conditions con	tributing to death bu	t not resulting in the	underlying ca	use give	n in Part I.				ribute to th	ably 4 DUKnown
Record	The law requate has been page 2 shoul	Completed	-							24a. Was an autopsy perform	ed?	erior to con death?	psy findings available inpletion of cause of
Vital	sicien: The certificate rector, pag	Be (25. Was case referred to medical examiner?						of Death	(Check only one)		
of \	this aldid	٦.	1 ☐ Yes 2 ☑ No H	ospital:				4 Nul		ne 5 🗆 Resider 28d. Describe hov)
	De Te	tion	1 Vatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	M	3c. Injury Work 1 🔲 Y	? ′es 2 🗍 N		.00. 2030/100 1101	a injury coodin	ou .	
Division	of or Attending after death. I Director: After d in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm, (Specify)	street, factory,	office		2	8f. Location (Stre City or Town,		er or Rural	Route Number,
	Hospite 4 hours Funere tely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	iician: To the best o ter: On the basis of and manner stat	examination and/or	ath occurred a investigation,	at the timi	e, date and inion, deat	d place, a	and due to the car ed at the time, da	use(s) and ma te and place, a	inner as sta and due to	ated. the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifier	N	1-1	NO 29c.	License	number 507	2	5 29	d. Date signed	d (Month, E	2004
			30. Mame and address of person who co	mpleted cause of de	ath (Item 23a) (Typ	e, Print)	ahs	Ha	141	Willer	sulle	M	2004
	Sta Registi		31. Date filed (Month, Day, Year) DEC 1 3 20	104 82. registra	's Signature	book	,	-0	1				9

Director Company Comp	Anne Ins. 8. Date of Birth (Month, Day, Year) 02/19/1923 10g. Citizen of U.S.A (Specify Yes or No- erto Rican, etc.) 14. R. B. Spec working 16b. Kind of Uni	3. Time of Death 2004 8:30 PM 19 of Death Arundel 9. Birthplace (State or Foreign Country) Georgia 10d. Inside City Limits 11 Yes 2 \(\subseteq \) No of What Country? ace - American Indian, lack, White, etc. sify: Black Business/Industry ted States
Physician /Medical Examiner Robert Pruitt 4a. Facility Name (If not institution, give street and number) Heritage Harbour Health & Rehab Center Annapolis Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F Months Days Hours Number 235-28-8678 Usuel Residence of Decedent	Nonth Day 13	yeer 2004 8:30 PM Iny of Death Arunde1 9. Birthplace (State or Foreign Country) Georgia 10d. Inside City Limits 1 X Yes 2 □ No If What Country? ace - American Indian, lack, White, etc. ify: Black Business/Industry
Medical Examiner An Examin	4c. Cour Anne	Arunde1 9. Birthplace (State or Foreign Country) Georgia 10d. Inside City Limits 1 X Yes 2 No of What Country? ace - American Indian, lack, White, etc. Business/Industry
Heritage Harbour Health & Rehab Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year 1f Under 24 F 235-28-8678 1 XM 2 F 81 Yrs. 4 Months Days Hours Multiple Security Number 1 Security Number 24 F 81 Yrs. 4 Months Days Hours Multiple Security Number 1 Security Number 24 F 81 Yrs. 4 Months Days Hours Multiple Security Number 24 F 81 Yrs.	Anne Second Service	Arundel 9. Birthplace (State or Foreign Country) Georgia 10d. Inside City Limits 11X Yes 2 No of What Country? ace - American Indian, lack, White, etc. bify: Black Business/Industry
Funeral Director 5. Social Security Number 6. Sex 1 XM 2 F 81 Yrs. 5. Social Security Number 24 F 81 Yrs. 6. Sex 1 XM 2 F 81 Yrs. 7. Age (In yrs. last birthday) Months Days Hours Number 24 F 81 Yrs.	In. 8. Date of Birth (Month, Day, Year) (02/19/1923) 10g. Citizen of U.S.A (Specify Yes or Noerto Rican, etc.) 16b. Kind of Unitist Arms	9. Birthplace (State or Foreign Country) Georgia 10d. Inside City Limits 1 X Yes 2 No of What Country? ace - American Indian, lack, White, etc. sify: Black Business/Industry
Director 235-28-8678 1 XM 2 F 81 Yrs. Months Days Hours N Usuel Residence of Decedent	U.S.A (Specify Yes or Noerto Rican, etc.) 16b. Kind of Unitation Unitation Arms	Georgia 10d. Inside City Limits 1 N Yes 2 □ No of What Country? ace - American Indian, lack, White, etc. sify: Black Business/Industry
	(Specify Yes or Noerto Rican, etc.) (Specify Yes or Noerto Rican, etc.) 14. R B Specify Yes or Noerto Rican, etc.) 16b. Kind of Unities 11st Arms	1 X Yes 2 □ No If What Country? ace - American Indian, lack, White, etc. eity: Black Business/Industry
Maryland Anne Arundel Crofton 106. Street and Number 106. Zip Code	(Specify Yes or Noerto Rican, etc.) (Specify Yes or Noerto Rican, etc.) 14. R B Specify Yes or Noerto Rican, etc.) 16b. Kind of Unities 11st Arms	of What Country? ace - American Indian, lack, White, etc. bify: Black Business/Industry
10e. Street and Number 1723 Gabriel Court 1. Marital Status 1. Maver Married 2 Married 3 Widowed 4 Divorced 1. Decedent's Education (Specify only highest grade completed) 10f. Zip Code 21114 11. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Specify Cuban, Mexican, Pt 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 2 No	(Specify Yes or Noerto Rican, etc.) (Specify Yes or Noerto Rican, etc.) 14. R B Specify Yes or Noerto Rican, etc.) 16b. Kind of Unities 11st Arms	ace - American Indian, lack, White, etc.
1723 Gabriel Court 1. Marital Status 1. Married 2 Married 3 Widowed 4 Divorced 1. Decedent's Education (Specify only highest grade completed) 1723 Gabriel Court 12. Was Decedent Ever in U.S. Armed Forces? 1 Married	(Specify Yes or Noerto Rican, etc.) 14. R B Specific Spe	ace - American Indian, lack, White, etc. ify: Black Business/Industry
11. Marital Status 1 Never Married 2 Married 1 Never Married	erio Rican, etc.) Spec working Uni list Arm	lack, White, etc. cify: Black Business/Industry
1 Never Married 2 Married 1 Mayes 2 No I Yes	working 16b. Kind of Unilist Arm	Business/Industry
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life DO NOT use retired)	Vni list Arm	
(Specify only highest grade completed) (Give kind of work done during most of life DO NOT use retired.)	Vni list Arm	
N ≦ 6 5 8 Elementary/Secondary (0·12) College (1·4or 5+)	list Arm	
(Specify only highest grade completed) Specify only highest grade completed Give kind of work done during most of life. DO NOT use retired	lame (First, Middle, Maiden Sumi	_
Tr. Father's Name (First, Middle, Last) 18. Mother's I 19. Tather's Name (First, Middle, Last) John Pruitt Marga		ame)
	ret Carson	
2 2 a a a		
Bernice Pruitt - Wife 1723 Gabriel Court, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place)		nd 21114 n - City or Town, State
Certificative Clear and Control of Control o		
1 Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place) Huntt Crematory 12 21. Signature of Edneral Service Licensee 22. Name and Address of Facility 16000 Annapolis R	/15/2004 Waldori	
16000 Annapolis R		
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Physician Physician Physician		Approximate Interval Between Onset and Death
Medical Due to (or as a consequence of):		
Examiner . Sequentially list conditions b. HIALS TANKEY		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
if if cate as the last the las		
IF FEMALE: 23c. If yes, outcome of pregnancy	23d. E	Date of delivery
In the past 12 months?		fonth Day Year
1 Yes 2 No 9 Unknown Unknown Part II, Other significant conditions contributing to death but not/resulting in the underlying cause given in Part I.		
		ntribute to the cause of death?
strong side of the staff light Detallita relations and specifications and staff light of the staff light light of the staff light light of the staff light light of the staff light	1 Yes 2 No	3 Probably 4 Unknown
	- autopsy	. Were autopsy findings available prior to completion of cause of
= . a r 1/	performed? 1 ☐ Yes 2 🔼 No	death? 1 ☐ Yes 2 No
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 11 Yes 2 No	Death (Check only one)	
1 Page 2 No Properties 1 Inpatient 2 ER/Outpatient 3 DOA Office: 4 Norsing 1 Inpatient 2 ER/Outpatient 3 DOA Office: 4 Norsing 1 Inpatient 2 ER/Outpatient 3 DOA Office: 4 Norsing 1 Inpatient 2 Deposition 1 D	Home 5 Residence 6 O	
D = 5		
28a. Date of Injury 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 2 Pending investigation 5 Pending investigation 6 Pending investigation 6 Pending investigation 6 Pending investigation 7 Pending investigation 8 Pending investigation 9 Pending investigation 9 Pending investigation 1 Pending inve	28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
25. Was case referred to medical examiner? 1	ice, and due to the cause(s) and n courred at the time, date and place	nanner as stated. e, and due to the cause(s)
29c. License number	29d. Date sign	ed (Month, Day, Year)
D38958	12/14	104
30. Name and seems of person who completed cause of 13 th (Item 23a) (Type, Print)	1 11	1+
Dateet Sarch Feller 1413 Honofold No	ay #106 04	en/on MD21113
State 31. Date filled (Mohth, Day, Year) 3. Registrar's Signature Registrar DEC 1.5. 2004		

			1 - State Amend Item 268 Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Death	Rag. I	N2004 41696
	Physicia		ASHTON TIMOTH	Y PRESTON			16, 2004 1:19a M
	/Medic		4a, Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death
	Examin	er	JOHN HOPKINS HOSP	·	BALTIMORE CITY		,
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yes	9. Birthplace (State or Foreign Country)
	Director		217-67-0128	1 Yrs.	Monato Bayo House	Aug. 13,	2003 Maryland
	and w	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Maryl f sho	ţō	Maryland Harford	Darling	ton		1 ☐ Yes 2 No
	r 28e	Director	10e. Street and Number	Daring	10f. Zip Code	10g.	Citizen of What Country?
	h with		2603 Castleton	Road	21034		USA
	ams a	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1X Never Married 2 Married	1 ☐ Yes 27 No If Yes, Give	1 ☐ Yes 🏖 No Specify:		Specify:
ö	d within 72 hours after death with the Maryland jiene. I them naturel', or Itams 23a or 28e-f show It e Madical Examination at the notified at		3 Widowed 4 Divorced	Year or Dates:	edent's Usual Occupation	16h	White Kind of Business/Industry
215-0036	in 72	Completed	(Specify only highest grade	completed) (Giv.	e kind of work done during most of working DO NOT use retired)	ng Tob.	Killa of Basilless/floasily
212	d within giene. r then "	ШО	Elementary/Secondary (0-12)	College (1-4or 5+)	Infant		
b	ba filed ttal Hygid td other event, L	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	len Sumame)
ylaı		70	Timothy Lewis	Preston	Kelley	Jean Br	iggs
Maryland	0 0 0		19a. Informant's Name/Relationship (Ty) Kelley J. Briggs		ling Address (Street and Number or Rura)3 Castleton Road,		
	l an leath	i	20a. Method of Disposition	20b. Place of Disp			Location - City or Town, State
altimore,	T of		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State cemetery, cre	ematory or other place)		
Ħ	permit. Page Department Important: I any injury o		4 □ Donation 5 □ Other (Specify) 21. Stout re of Funeral Service License		W Memorial Gardens		Fallston, Maryland
Ba	Depa Impo any ir		Alle Man	antonist	MCComas Funeral Ho 1317 Cokesbury Roa		on Marriland
			23a. Part1. Ente the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not er			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Methadone Intoxica	ation		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	201011		
	Examiner		Sequentially list conditions, b				
	ed isit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dualty (or as a nor sequence of):			
	be exacuted sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
8760,	death certificate be exacuted e attending physician and od for use as the burial-transil	dical E		1			
89	ifficate I g physi as the t	0					
ŏ	eath certific attending p for use as 1	M/us	230. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
B.		Physician/M	in the past 12 months? 1 Yes 2 No		Other (specify)		Month Day Year
P.0	at the de d by the etached	Phy	9 Unknown			22a Did tabasa	o use contribute to the cause of death?
	law requires that the as baen signad by th 2 should be detache	by	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		2 No 3 Probably 4 Unknown
ecords,	w requir baen si should	Completed					
Rec	Tha taw ite has I	dE				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
la I		e Co	25. Was case referred to medical		CO Plane of Possible	1 Yes 2	
Vital	Physician: this certific ral director,	OB	eyaminer?	lospital: 1 ☐ Inpatient 2 X ER/Outpatie	26. Place of Death		6 ☐Other (Specify)
) of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time		28d. Describe how in	
jo	Attending I r death. actor: After by the funer	atlo	1 Natural 5 Pending investigation	12-16-04 7:15		ubject in	gested methadone
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, St	and Number or Rural Route Number, Rd.
	urs af oral D			Home		ariington	, rid
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	O C	29c. License number		Date signed (Month, Day, Year)
)	r s r ō		Met ()	Kalloo ~	OCME		CEMBER ,2004
•			100000				
			30. Name and address of person who co	empleted cause of death (Kem 23a) (Type	e, Print)	T. (ODD - 1115	57T ANTO 04004
			30-Name and address of person who co	ompleted cause of death (Nem 23a) (Type	Print) PENN STREET, BALT	IMORE, MAR	YLAND 21201

December 1 December 1 Americal School (American School American School America				1 - State Registrar	te of Maryland	•	ertment of H		, ,	ene g. No.2 A A	
Wella S. Robinson December 10 2004 11:25 AM									2. Date of Death	~ U U	3) Tine Death
## Company Security Numbers Control of Death Court South Security Numbers Court	н	_		Welba S. Ro	binson						
Social based promptor Soci				4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of De			
228 AQ 1969 18M 30F 81 vs. Water Days Nove Mo. John John John John John John John John	п			22504 Robin Court			Gaithe	rsburg		Monte	gomery
The composition of the composi					-				rs. 8. Date of Birth (Month, Day, Jan. 19	1923	D. Birthplace (State or Foreign Country) Virginia
The standard Name (First, Middle, Last) Earl Robinson 18. Mother's Name (First, Middle, Last) Earl Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns Name) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns Name) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns Name) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns Name) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns Name) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns Name) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments Cultural Towns) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments) Sylvia D. Robinson 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or Plant Flower Auments) 19. Mailing Address (Sites and Number or P		and w			10c, City.	Town or Lor	cation				10d Inside City Limits
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Provided to the death of the de		alth alth a		Sylvia D. Robinson /	Wife	2250	4 Robin (Court,	Gaithersbu	rg, Md.	20882
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Due to (or as a consequence of):		Pnysician		Immediate Cause (Final		CANC	FR				Onset and Death
Sequentially list conditions as consequence of): Sequentially list conditions are sequenced of light of ligh				resulting in death)							10 12/11/0
Due to (or as a consequence of): Due to (or as a consequence of):		Examiner		Sequentially list conditions. b.							
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FFEMALE: 23d. Date of delivery Month Day Year		and and	каш	that initiated events	ue to for as a conseque	ance of):				_	
FFEMALE: 23c. If yes, outcome of pregnancy 1 Live bith 2 Fetal death 3 Ectopic pregnancy 1 Live bith 2 Fetal death 4 Pregnant at time of death 5 Cither (specify) 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 2 No 1 Yes 2 No 9 Unknown 2 Probably 4	60,	be ex ician burial	al E		ne to (or as a conseque	arice oi).					
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE A. SOTOS, M.D. 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD. 20850 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the To the Comp	ž			7			290	d. Date signed (A	Month, Day, Year)
GEORGE A. SOTOS, M.D. 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD. 20850 State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature)	Coti		1 grain	C 20	4-	D43	3083		DECEMBER	10, 2004
Citate 1		WII						DRIVE,	ROCKVILLE,	, MD. 2	0850
Registrar		Sta Registr		31. Date filed (Month, Day, Year) DEC 13 2004	32. Registrar's Signatu	ire 🏂	porks	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	oraro or many tann	Cei	tificate of	Death	Reg	2 U U 4	41698
	Physici	an	1. Decedent's Name (First, Middle, La		20 -			2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	Michael Ch 4a. Facility Name (If not institution, given the property of the p	re street and number)	rtson		r Location of Death	December	10, 2004	
	Funeral Director		5. Social Security Number 6. 3 209–28–8949	Sex 7. Age (In yrs. I	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	-	8. Date of Birth (Month, Day, April 25	9. Bir Co , 1938 En	thplace (State or Foreign buntry) gland
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		r, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 14116 D Lauren L	ane		10f. Zip Code 20707			g. Citizen of What Co nited Sta	
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avant, the Mydical Examinar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Syes 2 No If Yes, Give Year or Dates: 157-1	s. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi Specify: Wh	te, etc.
21215-0	within 72 ho ene. than "natu	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	16a. Dece (Give life.		pation during most of work d)	ing	6b. Kind of Business Jet Pulpu	
ınd 21	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " reaumatic avant, Ite Med	Be	12 17. Father's Name (First, Middle, Las		SCIE	ntist		e (First, Middle, M		ISION
Maryland	d 2 should th and Men 7 is marke traumatic	2	Thomas Ferguson 19a. Informant's Name/Relationship Steve Morusiewic	(Type, Print)		ng Address (Street Lake Sho		al Route Number,	City or Town, State,	
Baltimore, I	Pages 1 and 2 ent of Health nt: if itam 27 i		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Spec	20b. P □Removal from State	lace of Dispo emetery, crei	esition (Name of matory or other place itan Crem	Dec.	Date 2	Oc. Location - City or	
Balti	permit. Pages Department of Important: if ii any injury or once.		21. Sign to firule al 3 ice Lice	ensee	22	2. Name and Addre	ss of Facility Adv	ent Fune	ral & Cre apolis, M	mation Ser. D. 21401
	Prrysician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death y one cause on each line. a. Due to (or as a consequence)	sacci		1.7	stades	st,	Approximate Interval Between Onset and Death
68760,	ritificate be executed ng physician and as the burial-transit	Medical Examiner	Sequentially list conditions, a y lacting to immodal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) Due to (or as a consequence)						
.O. Box 68	The law requires that the death certifics the has been signed by the attending ptoage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3[Ectopic pregnancy	y	•	23d. Date of de Month	livery Day Year
4	w requires that t been signed by should be detai	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.			o the cause of death?
of Vital Records,		Completed						24a. Was an autopsy perform 1 \(\text{Yes} \) 24	ed? 24b. Were a prior to death?	utopsy findings available completion of cause of
Division of Vita	or Attending Physician: Thater death. Director: After this certificate in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigating Suicide 6 Could not	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	end 4 □ Nursing Ho y at rk? Yes 2 □ No	th (Check only one) me 5 Resider 28d. Describe how 28f. Location (Stre	nce 6 Other (Spe v injury occurred seet and Number or R	1,007
Div	- 9 = 6		4 Homicide determine	28e. Place of Injury - At he building, etc. (Specification)				City or Town,	State)	
	To the Hospital o within 24 hours at To the Funara D completely filled in	Medical	(Check only 2 Medical Exa	aminer: On the basis of examina and manner stated.	tion and/or in	vestigation, in my d	ppinion, death occur	red at the time, dat	te and place, and du	e to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier)		D 2			d. Date signed (Mon	
y			30. Name and address of person who	o completed cause of death (Item A Chry + CSPI CC			aw St	Baltine	ecember 1 ave MD 2	21201
	Sta Regist	ate rar	31. Date filed (Month, DEC 1	4 2004 32. Registar's Signa		South.				

DHMH 17 Rev 1/2001

Michael Robertson 12/10/24

		•	For Stete Registrar	State o	of Maryland / De	partment of ertificate of			giene Reg. No. 2	nn.	1.1600
	Physici		1. Decedent's Name (First, Middle	, Last)				2. Date of De Month DELEMB	Day	Year 2004	3. Time of Death
	/Medic Examin	al	Betty Ann Se: 4a. Facility Name (If not institution Baint Josep	stak , give street and nu on Medic	mber) al Center	4b. City, Town,				ty of Death	imore
	Funeral Director		5. Social Security Number 167–03–3764	6. Sex 1 ☐ M 2 X 1F	7. Age (In yrs. last birthd 86 Yrs	Months Days		Min. (Month, Da	y, Year)		olace (State or Foreign otry) osylvania
	land ow	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location				1	0d. Inside City Limits
	the Mary 28a-f sh offilied	Director	Maryland Wash	ington	Hagers	town 10f. Zip Code			10g. Citizen of	f What Cour	1 Tyes 2 No
	3a or	i Dir		o Dodina		2174	0		U.S.		NY.
	death	Funerai	17920 Oak Ridge 11. Marital Status	10 Man Dan	edent Ever in U.S.	2 Man Deceded of		in? (Specify Yes or No Puerto Rican, etc.)	- 14. Ra	ace - Americ ack, White,	
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. do other than "natural", or itams 23a or 28a-f show event, the Medical Eraninar must be notified at	by	1 ☐ Never Married 2 📉 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 [XYes If Yes, Gi Year or D	2 No 3-3-134 ive 6-13-194	.5 1 □ Yes 2 No			Spec		nite
5-0	"natu	Completed	15, Deceden (Specify only highes		(0	ecedent's Usual Occu ive kind of work done e. DO NOT use retin	during most	of working	16b. Kind of	Business/Ind	dustry
12	within lene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) ""	Homema.	,		Perso	nal Re	esidence
	e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle,	Last)		nomena		's Name (First, Middle			.bracilec
Maryland	l 2 should be filed with n and Mental Hygiene is marked other tha raumatic event, the	To E	Clifford Ray	Wade	F.,			n Josephine			
Mar	2 8 9 1		19a. Informant's Name/Relations					or Rural Route Numb	and the same	100	
	of Health item 27 other tr		Louis D. Sest	ak	20b. Place of D	sposition (Name of		r. Hagersto	20c. Location		
altimore,	A 0 .		1 Burial 2 XCremation 4 Donation 5 Other (S		State	crematory or other pl ourg Crem	· 1	12/22/04	Smiths	burg 1	Maryland
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Foneral Service	Licensee	ulay tr			Douglas A.	_		ral Home yland 21742
	_		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death. Do not each line.			-		1	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	ADU	LT RESPIRE	TORY DIS	STRESS	SYNDROM	grame Javos Reduca		Onset and Death B WEEKS
	/Medical Examiner		resulting in death)		(or as a consequence of) ONARY ARTE		100				3.5WEEKS
	be is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consequence of)						
	cate be executed ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a consequence of)						
8760,	ysiciar e buri			d							
9	ntificate ing phys e as the	Medi	IF FEMALE:								
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	utcome of pregnancy birth 2 ☐ Fetal death mant at time of death nown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			ate of delive fonth	ery Day Year
Д	juires that the d n signed by the ild be detached	by	Part II. Other significant condition	ons contributing to c	death but not resulting in th	e underlying cause g	iven in Part I.	23e. Did t	_/		ne cause of death?
Records,	The law requirestee that the same of the s	Completed						24a. Was auto perfo		were autoprior to condeath?	psy findings available impletion of cause of
of Vital	ysician: This contificate director, pag	Be	25. Was case referred to medica examiner?		/			of Death (Check only	one)		
of \	this al dii	2	1 Yes 2 No	Hospital: 1	Inpatient 2 ER/Outpa	Ment 3 DOX		sing Home 5 Resi			y)
UO	Attending r death. actor: After by the funer	tion	1 Natural 5 Pendir 2 Accident investi	ng (Mor	nth, Day Year) Inju	ry W	ork? □Yes 2□N		now injury occi	31100	
Division	t or Atten after dea Diractor	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At home, farm ding, etc. (Specify)	, street, factory, office	Ð	28f. Location (City or To	Street and Nun wn, State)	nber or Rura	l Route Number,
_	To the Hospitat or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifyir 2 Medicel	Examiner: On the b	e best of my knowledge, obasis of examination and/onner stated.	eath occurred at the or investigation, in my	time, date and opinion, death	I place, and due to the n occurred at the time,	cause(s) and n date and place	manner as st	tated. the cause(s)
		Me	29b. Signature and title of certifie	Maram	0		nse number		29d. Date sign	ied (Month,	Day, Year)
44	1+1		30. Name and address of person	who completed cau	use of death (Item 23a) (Ty		E TOWS	ON. MARY	QNID =	1,200	
	Sta Regist		31. Date filed (Month, Day, Year)	2004	Pegistrar's Signature	frets	a See V V See			ale long Maria and	

			1 - For State Registrar	State of Maryla	•	artment of I			Reg. No. 2	004	41700
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last Irvin 4a. Facility Name (If not institution, give	Fleming			Lder	Decembe	r 19,	Year 2004 Inty of Death	7:20 P M
	Funeral Director		Western Maryland 5. Social Security Number 6. S	Hospital Cent	er . last birthday) Yrs.	Hagersto If Under 1 Year Months Days	own	s. 8. Date of Birt	Was , Year)	9. Birthp	on place (State or Foreign ptry) Sylvania
	the Maryland 28a-f show	rector	Usual Residence of Decedent 10a. State 10b. County MD Washing 10e. Street and Number		ity, Town or Lo						0d. Inside City Limits 1 1 Yes 2 □ No
9	72 hours after death with the Maryland Instural', or items 23e or 28e-f show Alcal Examilied of the Indiffied of	Funeral Director	629 N. Mulberry S 11. Marital Status 1 Never Married 2 Married	t. 12. Was Decedent Ever in the Amed Forces? 1 □ Yes 2 X No If Yes, Give	i	21740 Was Decedent of H If Yes, specify Cub 1 □ Yes 2 🖾 No	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	U . S	Race - Americ Black, White,	an Indian,
Maryland 21215-0036	d within 72 hours plene. r than "netural", ine Moulted Exc	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 1 2	Year or Dates:	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation	orking		Whi f Business/Ind	dustry
land 21	be filed tat Hyg od othe event,	To Be Con	12 17. Father's Name (First, Middle, Last) Adam Earl Snider		Offic	ee Worker		ome (First, Middle,			e Company
	1 and 2 sh Health and em 27 Is m ther treum		19a. Informant's Name/Relationship (Virginia M. Snide 20a. Method of Disposition	r/Wife	629 N	-	and Number or R	agerstown	ı, MD	vn, State, Zip 21740 on - City or To	
Baltimore,	permit. Pages Department of h Important: If ite any injury or of		1	Res	st Have	n Cemeter 2. Name and Addre	ry 12/2 ess of Facility Re	22/2004 est Haver	Hagers Fune	stown, ral Cha	MD
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	•	ith. Do not ent		ng, such as cardia			wn, MD	21742 Approximate Interval Between Onset and Death
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P.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)	,			Date of delive Month	ry Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not re							e cause of death? ably 4 SUnkn own
Vital Records,	The ate h page	e Completed	25. Was case referred to medical	umany a	'resr'			24a. Was a autops perform	med? 2 Ao	prior to con death?	osy findings available inpletion of cause of 2 No
o	I or Attending Physicien: after death. Director: After this certific: I in by the funeral director.	ertification: To Be	examiner? 1 Yes 2 PNo 27. Manner of Death 1 Hatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	28b. Time of Injury	f 28c. Injur Wor M 1 🗆	er: 4 🗆 Nursing I	ath (Check only or Home 5 Reside 28d. Describe he 28f. Location (Si	ence 6 Co ow injury occ	urred	
ā	Hospitel or 4 hours afte Funerel Dir ely filled in l	dical Certi	29a. Certifier 1 Certifying Ph	building, etc. (Special special specia	owledge, death	occurred at the tir	ne, date and place	City or Town	n, State) ause(s) and	manner as sta	ated.
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens		2	9d. Date sign	ned (Month, L	Day, Year)
_ <u>5</u> t	1-5		30. Name and address of person who a Vasant Datta	completed cause of death (Ite	m 23a) (Type,		Pennsylva stown, M				
	Sta Registr	-	31. Date filed (Month 1920 Year)	32. Régistrar's Sign	ature	miles					

			. For	State of	Maryland /	Departm				•	giene	_09.5	10.		
			1 - State Ragistrar			Certific	ate of	Death			Rag. No.	20	04	4-1	701
	Physicia	an	1. Decedent's Name (First, Middle, Las							2. Date of Dea Month	Day	200	Year	3. Time of	DM M
	/Medic	al	FAYE B. SCLICHT 4a. Facility Name (If not institution, give		er)	4b. C	ity, Town, o	r Location of		DECEMBE		County of		9:55	PM
	Examin	er	2989 JAMAICA PT		,		TRAPP					-	ALBO	\mathbf{T}	
	Funeral Director		5. Social Security Number 6. Se 204–28–0355	3x 7. □ M 2 🟋 7.	Age (In yrs. last bi	irthday) If Ur Yrs. Mont	hs Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da SEPT 28	h Year)	7	9. Birthpi Coun PA	lace (State o	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Location							11	0d. Inside Ci	ity Limits
	Maryll	tor	MD TAL	вот	T	RAPPE								1 🗌 Yes	¾ □No
	death with the Maryland rms 23e or 28a-f show rmst Le rediffed at	Director	10e. Street and Number			10f	Zip Code				10g. Citiz	zen of Wi	nat Coun	try?	
	23e c	ralD	2989 JAMAICA PT.					1673					USA		
36	should be filed within 72 hours after death with the Marylan of Mediath Hygiens are transfered to the than "naturel", or flems 23e or 28e-f show marked other than "naturel", or flems 23e or 28e-f show mails event, the Medical Exert are must be radified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give	es? MXNo		ecedent of H specify Cuba s 2 🙀 No	lispanic Ori an, Mexicar Specify:		acify Yes or No- Rican, etc.)			, White,	an Indian, etc. ITTE	
2-0036	ture!	ed b	15. Decedent's Ed	Year or Date		a. Decedent's I	Jsual Occup	ation		1	16b. Kir	nd of Bus	iness/Inc	dustry	
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and E	be fill ad other of the other of the other	Be	17. Father's Name (First, Middle, Last)	0						e (First, Middle,		Sumame)		
Maryland 2121	hould id Mer marke matic	ပ	FRANK A. BROOKEN 19a, Informant's Name/Relationship (7)		19	b. Mailing Add	ress (Street			ET BOHN al Route Numbe		Town, S	tate, Zip	Code)	
	ar is		CMDR. EDWARD F. S			•									
ore,	of Health of Health fitem 27 r other tr		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Romaval from St	comete	of Disposition ery, crematory	Name of or other plac	ce) 1:	2-11	-04	20c. Lo	cation - C	ity or To	wn, State	
Ĕ	Pages ment of ent: If it ury or o		'4 □ Donation 5 □ Other (Specify			PEAKE (REMAT					STE	VENS	VILLE	, MD
Baltimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funeral Service Licen	SEERCE	Ran	22. Nam FELLO 200 S	and Addre WS, H B. HAR	ss of Facilit ELFEN RISON	BEIN ST.	& NEWN EASTON	AM F MD	UNER 216	AL H	OME P	A
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	olications that cau	sed the death. Do	not enter the	mode of dyir	ng, such as	cardiac	or respiratory ar	rest,			Approximat Interval Bet Onset and I	ween
a.	Priysician		Immediate Cause (Final disease or condition resulting in death)	a. Res	sicutory	Feel	ure							Onsot and i	Death
	/Medical Examiner		resulting in death)	Due to (o	as a consequence		e			02207				413	4.7
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	cuted nd ransit	Examin	that initiated events	с.											
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<u> </u>	# × @	dlcal		d				_			_				
x 68	certifi Iding I	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy					1,1001	2	23d. Date	of delive	ırv	
P.O. Box	uires that the death certifica signed by the attending ph d be detached for use as th	Physiclan/Med	in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ∏Fetal deat nt at time of death ⁄n	th 3 ⊟Ectop 5 ⊟ Othe	ic pregnancy (specify) _	/				Mont		-	Year
σ <u>.</u>	s that ned b	y Pr	Part II. Other significant conditions c	ontributing to dea	th but not resulting	in the underlyi	ng cause giv	en in Part I		23e. Did to	bacco u	se contrib	oute to th	e cause of d	death?
ıds	w require been sig should b	ed t	End Stoye Rena	l Disco	se					1 🗆 1	/es 2∫	⊠ (No 3	Prob	abiy 4 □l	Jnknown
Vital Records,	Attending Physicien: The law requires that the death certifica rideath. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	Completed by										pri de	ior to cor ath?	osy findings npletion of c	available ause of
/ita	cien: ertifica actor,	Be (25. Was case referred to medical examiner?	119-1			Tou.		of Deat	Check only o	ne)				
o _	Phyei this c	۵,	1 ☐ Yes 25 No 27. Manner of Death	Hospital: 1 ☐ Inp		Outpatient 3	DOA		-	me 5 Resid				1)	
O	ding th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	28c. Injur Wor 1 🗀	rk? Yes 2∐		Edd. Describe (iow injury	y occurre	u .		
Division of	i Citt	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o	f Injury - At home, t , etc. (Specify)	farm, street, fa	ctory, office			28f. Location (5 City or Tox			or Rura	l Route Num	nber,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in	Medical C	29a. Certifier 1 Cartifying Ph (Check only 2 Medical Exan	ysician: To the b niner: On the bas and manne	est of my knowledg is of examination a r stated.	ge, death occur and/or investiga	red at the tir tion, in my o	me, date an opinion, dea	nd place, ith occur	and due to the red at the time,	cause(s) date and	and man	ner as st nd due to	ated. the cause(s	5)
	To the within To the	Me	29b. Signature and title of certifier	7 - 4			29c. Licens				29d. Date	e signed	(Month, I	Day, Year)	
	-)/St/	isuel	B. Pasin	k mn	Virgin	123	137	4	91)ec	200)4	
			30. Name and address of person who	completed cause	of death (Item 23a)	A. A	. 1			010					
		to.	B. Pasiuk, 433 31. Date filed (Month, Day, Year)		holme gistrar's Signature		roold	-m	0	21012					
	Sta Regista		DEC 1	3 2004	gistar's Signature	A. So	ule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 1 41702 For State 12-14-04 Registrer Amend #21. Per FH PCC Cr Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ochrecena /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Narsing Ctr DUTTONSVILLE Montgomery 8. Date of Birth (Month, Pay, Year)
June 17, 1924 Pennsylvania If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 30 Days Hours Min. 193140763 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 23a or 28a-1 show the Medical Examiner - ust by notified at 1 XYes 2 No Maryland Prince George's New Carrollton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6504 Inlet Street 20704 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Wes 2 ☑ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or itams 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or ita any injury or other traumatic event, the Mcdical Examina. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ WWII 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) US Gov't. Civil service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry A. Schrecengost Suzanna Lavery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6504 Inlet Street New Carrollton, Maryland 20704 Hugh Schrencengost (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Veterans Cemetery Dec. 15, 2004 Cheltenham, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licens 6512 N.W. Crain Hwy. Bowie, Maryland 20711 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary ASUT Biscar 20425 **Physician** Atheroslerotu /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 📆 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 □ No 1 Yes 2 🗹 No 1 Tyes the Hospital or Attanding Physician: nin 24 hours after death. the Funaral Diractor: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 🗹 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) Vithin 24

9 10 101

31. Date filed (Month, Day, Year) State DEC 1 0 Registrar

29b. Signature and title of certifier

Rochville Pike , Rochville 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD

D0053615

20852

29d. Date signed (Month, Day, Year)

Derember,

8 th

,2004

		1 - For State Registrar	State o	f Marylan	d / Depa	artment o	f Heal	th and	d Mental Hy	/giene	2004	41703
Phys	ician	1. Decedent's Name (First, Middle							2. Date of D	eath Oli	(62 1	3. Time of Death 11:48 Рм
/Me	dical	Bessie V. St	over	mbosl		4b. City, Tov	m or l occ	tion of Do			County of Death	
Exan	niner	4a. Facility Name (If not institution, St. Thomas Mor	_				tsvil		atri	1	rince G	
Funer	al	5. Social Security Number	6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Y	ear If U	nder 24 F		rth	9. Birth	place (State or Foreign
Direct		242-22-5052	1 ☐ M 2 🖾 F	81	Yrs.	Months Da	ays Ho	urs M	in. (Month, D 03 1	7 23		aster, S.C.
pug		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
//anyla	ō	,			shing							1⊠Yes 2 No
r 28e-	Director	10e. Street and Number				10f. Zip Co	de			10g. Cit	izen of What Cou	ntry?
h with	0		N.E.			2000	2				USA	
r deat	Funerai	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U. orces?	S. 13.	Was Decedent f Yes, specify	of Hispani Cuban, Me	c Origin? xican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ameri Black, White,	
s afte	5 F		ed 1 □ Yes If Yes, Gi Year or D	2 🖾 No ve		1□Yes 2⊠	No Spe	ecity:			Specify: Bla	ck
il Z I 3-UU30 within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show then "neturel" or Items 23e or 28e-f show	ed be	15. Decedent	s Education	ales.	16a. Dece	dent's Usual O	ccupation			16b. K	ind of Business/Ir	
ALD thin 72 en "ne	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4or 5+)		kind of work d DO NOT use re		most of	working			
A will as will as will as the as the	Com	9th.			Но	ousewif					own ho	me
yland ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, I	.ast)						lame (First, Middle		Sumame)	
Waryland ZIZI: 12 should be filed within h and Mental Hygiene. 7 is marked othar than " treumatic event, II E.M.	P		in (Time Criet)		10h Maili	an Address /Co			e Thompso		y Tour State 7	- Codol
Mal d 2 st th and 17 is n treun		19a. Informant's Name/Relationsh Leonard Stover)	•			Washingto			
tem 2		20a. Method of Disposition	, 200	20b. P		sition (Name of matory or other			Date		ocation - City or To	
Pages ent of I		1 1 5 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		State	• Oliv		ріасы)	12-	07-04	Was	hington	D.C
DENTIMOTE, Maryjania ∠1∠15-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28e-1 show any injury or other traumatic event, Ite Marital Examiner mast be notified at any injury or other traumatic event, Ite Marital Examiner mast be notified at		21. Signature of Funeral Service		, 110			ddress of f		arshall's	Fur	eral Hor	ne
a a a a a	once	Sp man	hall						. Washing			
icate be executed XE IN PARTY Physician and Incident Incidental Party Inci	al er dical Examiner	eaude. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consequence of or a consequence or a consequence of or a consequence or a consequence or a consequence or a consequenc	uence of): uence of):	Cardio	/ascu	lar])isease			Onset and Death
death certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live	tcome of pregna birth 2 ∐Feta nant at time of d own	Ideath 3	∃Ectopic pregn ∃ Other (s <i>pecif</i>					23d. Date of deliv Month	ery Day Year
VITAL KECOLDS, F.O. icien: The law requires that the certificate has been signed by the rector, page 2 should be detache	2	Caranhan 1 Tan fana	•	eath but not res	ulting in the u	nderlying caus	e given in l	Part I.		tobacco (he cause of death?
ecord: law require as bean sign 2 should b		Dementia							24a. Was		24b. Were auto	opsy findings available ompletion of cause of
The laverate has page 2		Dysphagia							perf 1 ☐ Yes	ormed?	death?	
VITAL P sicien: Th certificate rector, pag	Re	25. Was case referred to medical							Death (Check only			
OT V Physic this c	F			Inpatient 2	ER/Outpatier 28b. Time o		the state of the s	Nursin	g Home 5 Res			5/)
JIVISION OT VITA Tor Attending Physicien: after death. Diractor: After this certification by the funeral director.	Certification:	1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	ation	of Injury oth, Day Year)	Injury	М	Injury at Work? 1 ☐ Yes	2 🗆 No				
DIVI spitel or At ours after d haral Diract	Cortifi	4 Homicide determ	ined 289, Place	e of Injury - At ho ing, etc. (Specif	ome, farm, sti	eet, factory, of	fice		City or To	own, State	d Number or Run	al Houte Number,
the Hospitel hin 24 hours a	, logical	29a. Certifier 1 A Certifyin (Check only 2 Medical one)	g Physicien: To the Examiner: On the b and mar									
T S S S S S S S S S S S S S S S S S S S	Z		1	1.	10		cense num	nber			te signed (Month,	
(2)		1 San	Ilu	Me	n	Do	1852			Dece	mber 7,	2004
JC.		30. Name and address of person										
	State	Paul A. De Vor	e, MD. 4	203 Que Regiștrar's Signa	ensbur	y Road	, Нуа	ttsv	ille, MD.	_207	81	
	istrar	DEC 1 A ZIBA	Been	A A	and or							

			For State Registrer		State o	of Maryla			rtment of H				giene Reg. No.	004	1.3	704
			1. Decedent's Name (First, M	iddle, La	st)							2. Date of De Month	ath		3. Time o	of Death
	Physici /Medic		Cam L. Salladay	7								December	11, 2	2004 Year	1:19	a M
7	Examin		4a. Facility Name (If not instit	ition, giv	re street and nu	ımber)			4b. City, Town, or	Location	of Death		4c. C	ounty of Death	1	
			Washington Adve						Takoma				r	Montgome	ry	
	Funeral Director		5. Social Security Number 579–09–1361		Sex 1⊠M 2□F	7. Age (In y	rs. last birth 87 Yr	//	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Sept. 6,	y, Year)	Col	nplace (State untry) DWa	or Foreign
	pug *		Usual Residence of Deceden 10a. State 10b. Con			10c	City, Town	or Loca	ation						10d. Inside C	Titu Limite
	sho	ō		•												2 ∑ No
	28a-f	ect	Maryland Mor	itgame	ery		Mheaton		10f. Zip Code				10a Citiza	en of What Cor		
	with Fa or	ᅙ	2000 Franwall A	\	_								-		unity:	
	leath	era	11. Marital Status	wenue		edent Ever in	U.S.	13. W	as Decedent of H	ispanic Or	igin? (Sp	ecify Yes or No		JSA 4. Race - Amer	rican Indian.	
36	d within 72 hours after death with the Maryland Jiene. I then "natural", or Items 23a or 28a-f show The Marical Examirat must be muffled at	by Funeral Director	1 ☐ Never Married 2 ☐ i		Armed F	orces? 2 ☐ No ive		If `	Yes, specify Cuba □ Yes 2 X No	Specify:	n, Puerto	Rican, etc.)		Black, White Specify Whit e	e, etc.	
ŏ	72 hou		15. Dece		ducation		16a. D		nt's Usual Occup				16b. Kind	d of Business/l	ndustry	
21215-0036	within 7 iene. 'than "n	Completed	(Specify only his Elementary/Secondary (0-1)	-) (1-4or 5+)	1	ife. Do	ind of work done of NOT use retired	1)	t of work	king		copolitar Departmer		
D	Hyg ent,	Be C	17. Father's Name (First, Mid	dle, Last	')			1011	ice office.		er's Nam	e (First, Middle,	Maiden S	umame)		
Maryland	2 should be and Mental la marked cammatic even	To B	Walter J. Sall	aday						Fl	ossie	Clark				
ary	and A a ma		19a. Informant's Name/Relat	ionship (Туре, Print)		19b. N	Aailing	Address (Street	and Numbe	er or Rur	al Route Numbe	er, City or T	Town, State, Z	ip Code)	
	and 2 palth n 27 ler tra		Evelyn K. Gore	Fiar	ncee		11	601	Nairn Road	d, Whe	aton,	MD 20902				
Baltimore,	mit. Pages 1 and 2 should be partment of Health and Ments or trant: If item 27 Is marked a right prother traumatic e		20a. Method of Disposition 1 Mag Burial 2 □ Cremat 4 □ Donation 5 □ Other				o. Place of D cemetery, MD Veto Ceme	eran	tion (Name of atory or other plac 1 S 7	:e)	Decem	Date ber 16 04		ation - City or 1 enham Ma		
Balti	permit. Pag Depertment Important: any njury once		21. Signature of Funeral Sen	rice Lice	nsee	l.		22. Fran	Name and Addres ICIS J. Co. University		y Funer	al Home I	inc			
			23a. Part1. Enter the disease	or com	p cate ns that	caused the d								ig, MD ZC	Approxima	te
	Pnysician /Medical		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	List only	aO	nge	stiv	1e	Hea	rt	·F	ailur	e	-	Interval Be Orset and	Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cartes, 15-55, thuy that initiated events resulting in death) Last	{	c	(or as a cons		e 9	urgi	tati	ion	Jei Sei	ver	e	lma	ath
8760,	cate be executed physician and the burial-transit	dical E		l	_ d	(3) 20 2 20.00		-		<u>-</u> .						
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown			birth 2 ☐ F nant at time o	etal death		Ectopic pregnancy Other (specify)				23	d. Date of deliv	,	Year
<u>α</u>	es gu eş	ed by Pi	Part II, Other significant con	ditions	ontributing to a	death but not	resulting in the	e und	derlying cause give	en in Part I			obacco use /es 2 🗆	e contribute to		death?
Records,	e law has b	omplet	Cerebro	195	scula	r	CCIC	lei	nt			24a. Was autop perfo	rmed?	24b. Were aut prior to co death?	. /	available cause of
Vital	iclan: Th certificate rector, pag	d)	25. Was case referred to	dical	aci	WI	TEC	[]	OV)	26 Place	of Deat	1 ☐ Yes h (Check only o	2 No	1 🗆 Yes	218 No	
<u>></u>		ToB	examiner? 1 ☐ Yes 2 🗙 No		Hospital:	Inpatient 2	☐ ER/Outp	atient	3□ DOA Cthe	ar.		ome 5 Resid		Other (Speci	ifv)	
J Of	ig Physical dispersal di		27. Manner of Peath		28a. ate	•	28b. Tin	ne of	28c. Injun	/ at	_	28d. Describe h			,,,	
<u>Ö</u>	Attending r death. ector: After by the fune	atlo	72 LI Mooidaine	estigatio	n	in, buy rous	,,c	,,,		Yes 2	No					
Division	el or Atte s efter de sl Directo	Certification:		uld not b termined	28e. Plac	e of Injury - A ling, etc. (Spe	t home, farm ecify)	, stree	et, factory, office			28f. Location (S City or Tow		Number or Rur	al Route Nun	nber,
	To the Hospitel or Attending Phwitin 24 hours eiter death. To the Funerel Director: After the completely filled in by the funeral	edical (29a. Certifier 1 Cert (Check only one) 1 Med	ifying Pl	miner: On the	e best of my l Sasis of exam nner stated.	nowledge, of ination and/o	death o	occurred at the timestigation, in my of	ne, date an pinion, dea	d place, th occur	and due to the ored at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. to the cause(s	5)
	To th withir To th comp	Me	29b. Signature and title of ce	tifier	1//	/ /	/		29c. License	number	1		29d. Date s	signed (Month,	, Day, Year)	
)	12		1 Komo	7	1. (B)	mule	-, M	D.	. DO	05%	24	01	Dece	mber	~ 11. c	2004
	10-		30. Name and address of per	son who	completed cau	se of death (I	tem 23a) (T)	/pe, Pr	arrollA	venu	e'	Takon	na Pi	ark.M	D 20	19/2
	Sta Registr		31. Date filed (Month, Day, Y		2004 32.1	Registrar's Signature	nature	9	Spork	2	-			1		

	1	For State Registrar	State of Maryland /	Department of Health and N Certificate of Death	Mental Hygie Reg.	C004 41/11
Physicia /Medica	ın al	1. Decedent's Name (First, Middle, La		Thouse	2. Date of Death Month	Day Year 3. Time of Death
Examine Funeral Director	51	487-10-8728	lotical en	4b. City, Town, or Location of Death inthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 2,	4c. County of Death 9. Birthplace (State or Forei Country) KS
when the foods also deals with the mayand then "natural, or flems 23e or 28e-f show the "Medical Evaniter must be notified at			Arundel 10c. City, Tov	vn or Location Arnold		10d. Inside City Limi 1 ☐ Yes 2 🔯 N
s 23e or 2	Funeral Director	10e. Street and Number 194 Severn Way	Lea W. D. L. 15	10f. Zip Code 21012		Citizen of What Country? USA
Department of Harib 2 should be fined within 1.2 hours are locally min the waryan popartment of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evandrar chart be notified at ODGs.	þ	11. Marital Status 1 □ Never Married 2 【 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 Types 2 □ No If Yes, Give WWII Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Decry Yes or No- Diffican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
hen "nature Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	1	. Kind of Business/Industry Health Care
Mental Hygiene arked other thei atic event, the fi	o Be Co	17. Father's Name (First, Middle, Last John Behrens Tac			e (First, Middle, Maid ret Young	
Health and Men ther treumatic		19a. Informant's Name/Relationship (Jean Showe/Husba		b. Mailing Address (Street and Number or Ru. 194 Severn Way, Arno	ral Route Number, Ci	ity or Town, State, Zip Code)
Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State MD V		2004 C	c. Location - City or Town, State
Departr Importe any inji		21. Signature of Funeral Service Lice	at Lilla	Banama and Address of Facility P. 495 Gov. Ritchie Hv. not enter the mode of dying, such as cardiac	vy, severn	a Park, MD 21146
hysician /Medical xaminer	ē	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	aDue to (or as a consequence	micular Bleed		Sydays
sicie bur	ai Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.	100	Italiac	Bleed 8 days
itending physicle or use as the bur	ai Exa	that initiated events	· Hypertens	vof):	Iraline	23d. Date of delivery Month Day Year
igned by the attending physicle be detached for use as the bur	by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (of as a consequence d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ate has been signed by the attending physicie page 2 should be datached for use as the bu	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (of as a consequence d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)	23e. Did tobac	23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unkno
ifer this certificate has been signed by the attending physicie ineral director, page 2 should be detached for use as the but	To Be Completed by Physician/Medical Exal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Pending	Due to (of as a consequence d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting Hospital: Inpatient 2 ER/O 28a. Date of Injury (Month, Day Year) 28b.	in the underlying cause given in Part I.	23e. Did tobace 1	23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknot prior to completion of cause death? 1 Yes 2 No
Ifer this certificate has been signed by the attending physicie ineral director, page 2 should be datached for use as the burneral director.	To Be Completed by Physician/Medical Exal	In that end events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of the past 12 months of the past 12 months? 1 □ Yes 2 □ No 27. Manner of Death 1 Natural 5 □ Pending	c. Due to (of as a consequence of 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting contributing to death but not resulting to death but not resulting 28b. Date of Injury (Month, Day Year)	in the underlying cause given in Part I. 26. Place of Dea Other: 4 Nursing H. Time of Injury M 1 Yes 2 No	23e. Did tobace 1 Yes 24a. Was an autopsy performed 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how i	23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unkno 24b. Were autopsy findings availa prior to completion of cause death? 1 Ves 2 No 6 Other (Specify) Injury occurred
in 24 hours after death. Ne Funerel Director: After this certificate has been signed by the attending physicie pietely filled in by the funeral director, page 2 should be detached for use as the but the bu	Be Completed by Physician/Medical Exal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions december 21 No 12 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 11 Certifying Place.	Due to (of as a consequence of 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting contributing to death but not resulting 28a. Date of Injury 28b. Place of Injury At home, foundating, etc. (Specify)	in the underlying cause given in Part I. 26. Place of Dea Other: 4 Nursing H. Time of Injury M 1 Yes 2 No	23e. Did tobace 1 Yes 24a. Was an autopsy penformed 1 Yes 2 So th (Chack only one) ome 5 Residence 28d. Describe how i 28f. Location (Stree City or Town, S) and due to the causered at the time, date	23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknot 24b. Were autopsy findings availa prior to completion of cause of death? 1 Yes 2 No 6 Other (Specify) Injury occurred It and Number or Rural Route Number, tate) e(s) and manner as stated.

			For For	State of M									•		700
			State Registrar			Cei	tificat	e of L	Death			Reg. No.	004	+ 41	106
	Physicia	an	Decedent's Name (First, Middle, Last								2. Date of De Month	Day	Year	t t	DM
	/Medic Examin		Mossie Lee Segra 4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o		Decembe		2004 County of De		
	*	CI	Anne Arundel Medi		r			i	Annap				Ann∈	Arunde	1
	Funeral		5. Social Security Number 6. Se	x 7. Ag ☐M 2] F		ast birthday) Yrs.	If Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 4	th 1 <i>y, Year)</i> 1, 19	9. B	irthplace (State Country)	or Foreign
	Director		232–46–0480 Usual Residence of Decedent		75						Jule -	±, 19	29 WE	est Virg	ши
	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show than "naturel", or items 23e or 28e-f show Its M. offal Extrains.	7	10a. State 10b. County Maryland Anne Aru	ndel	10c. City	, Town or Lo	cation	An	napol	is				10d. Inside 0	City Limits
	28a-f	recto	10e. Street and Number				10f. Zip					10g. Citiz	en of What (
	th with	Funeral Director	1282 Swan Drive						21	401			U.S.F	4.	
	tems refund	uner	11. Marital Status	12. Was Decedent Armed Forces?	,	S. 13.	Was Deced	ent of Hi	spanic Orig n, Mexican	gin? (Spe n, Puerto i	cify Yes or No Rican, etc.))- 1	 Race - An Black, Wh 	nerican Indian, nite, etc.	
036	J within 72 hours after death with the Marylan Jiene. I than "naturel", or Items 23e or 28e-1 show The Modeal Examination and be notified at	þ	1 ☐ Never Married XXMarried 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 If Yes, Give Year or Dates:	No		1 🗆 Yes	2XNo	Specify:				Specify:	White	
2-0	72 ho	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)		16a. Dece (Give	kind of wo	rk done a	<i>furing</i> most	t of worki	ng	16b. Kin	d of Busines	s/Industry	
21215-0036	within ene. than t	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	00 NOT us ACCO					Co	unty (Sovernme	ent
1d 2	Hyg ent,	Be Co	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle	, Maiden S	Sumame)		
ylar	2 should be a and Mental Is marked o aumatic eve	ToE	Ted Walls								Della I		-		
Maryland	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic		19a. Informant's Name/Relationship (T			7	_				nnapol:)1
	s 1 and 3 if Health item 27 other tra		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei	sition (Nar	ne of	1		ate			or Town, State	
Baltimore,	Pages ment of I ant: If its lury or o		1 XBurial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify))		lcrest	Mem.	Gar	dens		and the same of th			s, Maryl	
Balt	permit. Pages Department of I Important: If it any injury or o once.		21. Signature of Fundral Prvice Libert	lean										ral Home , MD 21	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each I	d the death	n. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxima Interval Ba Onset and	itween
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	201		Car	ree						two	
ė	Examiner			Due to (or as	a consequ	uence ot):								Yeu	V
	po tig	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets)	Due to (or as	a consequ	uence of):									
	te be executed ysicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):		-	-	-					
760,	~ ~ ~	cai		d										7	2
89 X	ertifica ling ph e as th	Med	IF FEMALE:	20. 1	-4										
Вох	leath certificat attending phy ifor use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3[Ectopic p					2	3d. Date of d Month	elivery Day	Year
P.O.	that the de led by the a detached i	hysi	1 □ Yes 2 Ø No 9 □ Unknown	9□ Unknown											
	Se Co	by	Part II. Other significant conditions co	ontributing to death I	out not resi	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did t		/	to the cause of Probably 4	
Sorc	w requir been si should	leted									24a. Was	,		autopsy findings	
Vital Records,	The lav	Completed								<u>.</u>	auto		prior to death? 1 □ Ye	completion of	cause of
/ital		BeC	25. Was case referred to medical examiner?							of Death	Check only	/			
of \	Physic this c	은	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inj		ER/Outpatier		Othe 28c. Injury	4 🗆 190		me 5 Resi 28d. Describe		_ ``	ecity)	
	nding F th. : After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Di	ay Year)	Injury	M	Work	<br Yes 2 ☐		Edu. Describe	now injury	occurred		
Division	r Attendi er death. rector: A r by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	jury - At ho tc. <i>(Specif</i>)	ome, farm, sti	reet, factor	y, office		-	28f. Location (City or To	Street and wn, State)	f Number or i	Rural Route Nur	n <i>ber</i> ,
0	pitel o		29a. Certifier 1 Certifying Phy	/sician: To the best	of my kno	wledge dest	h occurred	at the tim	ne date an	d place :	and due to the	causa(s)	and manner	as stated	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examone)	iner: On the basis of and manner s	of examina	tion and/or in	vestigation	, in my of	pinion, dea	th occurr	ed at the time,	date and	place, and d	ue to the cause	s)
	To the To the comp	M	29b. Signature and title of certifier	mn	N				e number	0/		29d. Date	signed (Mo	nth, Day, Year)	201
7			30. Name and address of person who	completed course of	death (Ita-	2921/7		100	5130	01		000	- Mog	n 14,21 MO 21	Uge
			Kenn Bknok	MD 90	00 P	25740th	1	ad :	SITH	300	A.	nug e	dis	MO 21	401
	Sta Regist		31. Date filed (Month, Day, Year)		rar's Signa	ture						,			
DH	MH 17 Rev 1/2	-	DEC 15	2004		15.	TOO IS								-

ORIGINAL

		•	1 - For Stete Registrar	Old		aryland / De <i>C</i>	ertificate of			Z U U L	41/0/
			1. Decedent's Name (First, Mid	dle, Last)					2. Date of Death Month	Day Vees	3. Time of Death
	Physicia Medic/		John S.	Thomp	son J	r.			Decembe	r 10 200	8:25 M
3	Examin		4a. Facility Name (If not instituti	ion, give street a	and number)		4b. City, Town, o	r Location of Dea	ith	4c. County of Death	
			Anne Arundel	Medic	a 1 Co	ntor	Annano	lic		Anne Ar	ındel
Fu	uneral		Anne Arunde 1 5. Social Security Number	6. Sex 1 □ M 2	7. Age	nter (In yrs. last birthda	y) 11 Uhber 1 Year Months Days	Hours Mir			place (State or Foreign ntry)
Di	irector		216-68-8930	I XIVI 21		47 Yrs.			March 2		ryland
and	*		Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City, Town or	Location				10d. Inside City Limits
Aaryt	f sho	ō									1 ⊡Yes 2 □ No
the f	28a-	Director	Maryland Ann 10e. Street and Number	e Arun	idel	Church	10f. Zip Code		100	g. Citizen of What Cou	ntry?
with	l be	0		1] 1- +	D .	4	207	2.2			USA
Jeath	ns 2:	era	5442 Deale C	12. Wa	as Decedent 8		B. Was Decedent of H	lispanic Origin? (Specify Yes or No-	14. Race - Ameri	can Indian,
the contract of	rhar	by Funerai	1 Never Married 2 Ma	arried 1	ned Forces?]Yes 2 \ ∑N	lo	If Yes, specify Cub		rto Rican, etc.)	Black, White	
Surs S	Exi	þ	3 ☐ Widowed 4 ☐ Divorce	ed Ye	es, Give ar or Dates:		1 ☐ Yes 2 ☐XNo	Specify:		Specify: B1	ack
21215-0036 d within 72 hours after death with the Maryland giene.	natur Jical	Completed	15. Decede (Specify only high	ent's Education	oleted)	16a. De	cedent's Usual Occup ve kind of work done	ation during most of w	orkina 16	6b. Kind of Business/Ir	dustry
F iffi	Mes	nple	Elementary/Secondary (0-12		llege (1-4or 5	+) life	. DO NOT use retire	d)			
Ped v	it. Illi		12th	(1)	0		Self Emp			<u>Upholste</u>	ring
be fill	avan	Be	17. Father's Name (First, Middle		_				ame (First, Middle, Ma		
V Sould	narka	2	John S. T			405.14			erta J. N		0-1-1
Maryland of 2 should be file th and Mental Hy	Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic avant, It e Medical Examinations the natified at once.		19a. Informant's Name/Relation		•		illing Address (Street	and Number or F	turai Houte Number, (City or Town, State, Zi	² 0733
ore, Ma	am 2 thar		Ronald Thomp 20a. Method of Disposition	son (F	Brothe	120b. Place of Dis	42 Deale	Church	ton, Rd.	Churchton C. Location - City or T	
Baltimore, Department of Hea	or o		1X Burial 2 ☐ Cremation		al from State	cemetery, c	rematory or other plan U.M. Chu	rch		on Education Only of t	023590
ting the state of	rtant njury		`4 ☐ Donation 5 ☐ Other			Chews	Y 22. Name and Addre	112/	/15/04 LO	wensvill	e, Md.
Ba Perm Dep	any ir		Jarry H	Ass	MANA	Van		,	ns MOrtua napolis,	ry, P.A.	
			23a. Part1. Enter the disease,	or complications	s that caused	the death. Do not	821 West enter the mode of dyir	St. Ar	inapolis, ac or respiratory arres	Md. 214	Approximate
			shock, or heart failure. Li Immediate Cause (Final	ist only one caus	se on each lir	10.	011	10		10	Interval Between Inset and Death
	sician edical		disease or condition resulting in death)	d	W OK	a consequence of):	egricos.	Jung			NAID
	miner				1 KIN	Contra ci).	O ver	des		15	DAYS
		Je.	Sequentially list conditions if any, leading to immediate	b	Due to (or as	a consequence of):					
cuted	ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	5							
O, exe	an ar ırial-t	EX	resulting in death) Last		Due to (or as	a consequence of):					
68760, ficate be execut	physician and s the burial-transit	dicai		d						-	
	ing pi	a)	IF FEMALE:								
Box 6	attending _f	Physician/M	23b. Was decedent pregnant in the past 12 months?	1		2 Fetal death	B Ectopic pregnancy	/		23d. Date of deliv	ery Day Year
	the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Pregnant at □Unknown	time of death	5 ☐ Other (specify) _				
· =	ac	Phy	Part II. Other significant condi	tions contribution	ng to death hi	it not resulting in the	underlying cause an	on in Part I	23e Did toba	cco use contribute to t	he cause of death?
S O	g pe	by	Part II. Other significant contain	tions continuin	ng to death be	at not resulting in the	underlying cause giv	GITHIT CITI.		2 □ No 3 □ Prol	No.
ecords,	should	Completed									, /~
a ĕ	SO	npi								24h Wara auto	
⊕	e e								24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
~ §	page 2	Cor							autopsy performe	prior to co	ppsy findings available mpletion of cause of 2 No
~ §	ag ag	Be	25. Was case referred to medic examiner?		1· · · //		O#	oc	autopsy performe 1 Tyes 2 Death (Check only one)	prior to co death? YNo 1 □ Yes	mpletion of cause of 2 No
~ §	ag ag	To Be	examiner? 1 \(\text{Yes} 2 \)	Hospita	1mpatie			er: 4 🗌 Nursing	autopsy performed 1 Yes 2 Death (Check only one) Home 5 Resident	d2; prior to co death? No 1 Yes	mpletion of cause of 2 No
on of Vital R	After this certificate uneral director, pag	To Be	examiner? 1 Yes 2 Yes 27. Manner of Death Natural 5 Pend	Hospita 28a ding	I: Date of Injur		of 28c. Injur	er: 4 Nursing y at k?	autopsy performe 1 Tyes 2 Death (Check only one)	d2; prior to co death? No 1 Yes	mpletion of cause of 2 No
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ivision of Vital R or Attanding Physician: The ter death.	irector: After this certificate n by the funeral director, pag	To Be	examiner? 1 Yes 2 27. Manner of De In 1 Natural 2 Accident inves 3 Suicide 6 Coul	Hospita 28a ding stigation	Date of Injur (Month, Day	y / 28b. Time Injur	of 28c. Injur	er: 4 Nursing y at k?	autopsy performe 1 Yes 2 eath (Check only one) Home 5 Resident 28d. Describe how	d2: prior to co death? 1 Yes ce 6 Other (Special injury occurred	mpletion of cause of 2 No
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ivision of Vital R or Attanding Physician: The ter death.	irector: After this certificate n by the funeral director, pag	Certification: To Be	examiner? 1 Yes 2 Ye 27. Manner of Denth 1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul 4 Homicide 29a. Certifier I Certify	Hospita 28a ding stigation id not be mined 28e ying Physician: el Examiner: Qu	Date of Injur (Month, Day De Place of Injurbuilding, etc.	y 28b. Time Injur Iny - At home, farm, (Specify) of my knowledge, de examination and/or	of 28c. Injury M 1 1 street, factory, office	ver: 4 □ Nursing y at k? Yes 2 □ No	autopsy performs 1 □ Yes 2 □ eath (Check only one) Home 5 □ Residen 28d. Describe how 28f. Location (Stre City or Town, 25e, and due to the cau	d2: prior to co death? 1 Yes ce 6 Other (Special injury occurred	mpletion of cause of 2 No 2 No at Route Number,
ivision of Vital R or Attanding Physician: The ter death.	irector: After this certificate n by the funeral director, pag	To Be	examiner? 1 Yes 2 2 27. Manner of Denth Fivatural 5 Pend 2 Accident 3 Suicide 6 Coul 4 Homicide 6 Coul dete	Hospita 28a ding stigation id not be mined 28e ying Physician: el Examiner: Qu	Date of Injur (Month, Day) Place of Injur building, etc.	y 28b. Time Injur Iny - At home, farm, (Specify) of my knowledge, de examination and/or	of 28c. Injury M 1 1 street, factory, office	er: 4 Nursing y at k? Yes 2 No me, date and place	autopsy performs 1 Tyes 2 Peath (Check only one) Beath (Check only one) 28d. Describe how 28d. Describe how 28f. Location (Stre City or Town, 28d. and due to the causurred at the time, date	prior to co death? 1 Yes De 6 Other (Special injury occurred) et and Number or Runstate) se(s) and manner as see and place, and due to the signed (Month,	mpletion of cause of 2 No
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10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Black 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Approximate Interval Between Onset and Death 23d. Date of delivery Year Dav 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 No of Vital or Attanding Physician: Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1XXYes 2 🗌 No s after dec. FOUND Pay Year) 28b. Time of **UNK** 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred UNK Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 🙀 No 2 Accident 12-25-04 6 X Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Bouts Number, City or Town, State) 70 BAR HARBOR ROAD PASADENA, MARYLAND 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide FOUND AT RESIDENCE within 24 hours a To tha Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E DEC. 26, 2004 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Plan STREET, BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year 32. State Registra 2 8 2004

3. Time of Death

0715 A

1 Yes 2 No

			For Stete Registrar	State of M	arylan	-	artment of rtificate o		nd Mental Hy	giene	21 1700
			1. Decedent's Name (First, Middle	e, Last)					2. Date of De	ath CU (Year 3 Time of Death
	Physicia /Medic		Dorothy	Alice	Upo]	le				er 21, 2	
	Examin	er	4a. Facility Name (If not institution	n, give street and number))		4b. City, Town	, or Location of I		4c. County	of Death
			30-B Lewis B.			1	If Under 1 Yea	Oaklan			arrett
	Funeral		5. Social Security Number 219–34–5933	6. Sex 7. Ag 1 ☐ M 212 F	дө (in yrs. i 66	last birthday) Yrs.	Months Day		Min. 8 Date of Birt (Month, Da Feb. 2]	y, Year) 1, 1938	9. Birthplace (State or Foreign Country) Maryland
•	Director		Usual Residence of Decedent		00				reb. Zi	1930	maryland
Z Car	Wor #		10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
Ma	a-fst	ţ	MD G	arrett			0 a k]	and			1 □ Yes 2 ☑ No
ŧ	or 28	Jire	10e. Street and Number				10f. Zip Code)		10g. Citizen of W	hat Country?
4	1 23e	Funeral Director	30-B Lewis B.					21550		1	USA
a ra	ltems Darra	nue	11. Marital Status	12. Was Decedent Armed Forces	?	S. 13.	Was Decedent o If Yes, specify Ci	f Hispanic Origin Jban, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Hace Black	e - American Indian, k, White, etc.
5 te 5	F, or	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	INO	ļ	1 ☐ Yes 2 🖾 N	o Specify:		Specify.	White
IIIG Z IZ I 3-0030 he filed within 22 hours after death with the Mandard	ature			nt's Education		16a. Dece	dent's Usual Occ	upation	tdia	16b. Kind of Bu	siness/Industry
7 2	Medi "n	pie	(Specify only highs Elementary/Secondary (0-12)	completed) College (1-4or	5+)	life.	kind of work dor DO NOT use reti	ne auring most o red)	if working		
7	gien er th	Completed	12th			F	ersonal				ne Care
	d oth	Be	17. Father's Name (First, Middle,						s Name (First, Middle,	Maiden Sumam	
ar y la	and Mental Hygiene. is marked other than sumatic svant, the Me	은	Julian	Harrison	F	Ervin		Virgi		rene	King
- 0	h and h and 7 is m Iraum		19a. Informant's Name/Relations				•		or Rural Route Numbe		
בֿ ק			Russell E. Upo	le/Son	20b. P	lace of Dispo	sition (Name of		d, Oakland		LOOU City or Town, State
5	Department of Personal Inportant: If its any injury or ot once.		1 Burial 2 ☐ Cremation		, 0	emetery, crei	natory or other p		2121121		C 2640 30
	artme ortani injury		' 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Gar		O. Mem. Name and Add				Maryland
ם g	Dep		Ring	A TOO			tewart H			32 S. Se	Md. 21550
			23a. Part1. Enter the disease,	r complications that cause	d the death						Approximate
	nysician		shock, or heart failure. List Immediate Cause (Final				C 14		II D.I		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Afters			Cardiov	ascular	Heart Dis	ease	Years
E	xaminer		Sequentially list conditions,	b							
Ţ	2 %	iner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):					
ation	and and -trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	2 2005061	ionoo of):					
9	cian	E	Total Market State (1997)	Due to (b) as	a consequ	derice off.					
The law requires that the death conflicts to executed	physician and s the burial-transit	dicai		d		-					
) X C	requires traitine death centric been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregna	ncy				23d Date	e of delivery
ם ק	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnar Other (specify)			Mor	
; §	y the	nysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown							
F tag	ned be deta	by P	Part II. Other significant conditi	ons contributing to death I	but not resu	ulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use contr	ibute to the cause of death?
	quire an sig uld b								1 🗆 ١	res 2□No	3 ☐ Probably 4 ∏Unknown
ָבֵּי בָּ	as bee	piet							24a. Was autop		Vere autopsy findings available
בַ פַּ	certificete has rector, page 2	Completed							perfo	rmed? d	eath?
ָבָּ	artifice ctor, 1	Be C	25. Was case referred to medical examiner?	ıl				26. Place of	f Death (Check only o		
	this certificete har	2	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpati		ER/Outpatier	IL 3 DOA		ing Home 5 🔀 Resid		
	When the	on:	27. Manner of Death 1 Natural 5 Pendi		ury ay Year)	28b. Time o Injury	V			now injury occurre	ed
	tor: /	cat	2 Accident invest	not be				□Yes 2□No		Street and Number	er or Rural Route Number.
Z 2	after of Direction by in by	ertification;	4 Homicide determ	nined 28e. Place of in building, e	itc. (Specify	me, tarm, str /)	eet, factory, offic	æ	City or Tox		ar or nurar noute Number,
_ letina	ours a	0	29a. Certifier 1X Certifyi	ng Physician: To the best	t of my kno	wledge deat	h occurred at the	time, date and i	place, and due to the	cause(s) and mai	nner as stated.
H	24 h e Fur letely	edical		Exeminer: On the basis of and manner s	of examinat						
DIVISION OF VICE	to that may be a completely state of the within 24 hours after death. To the Funaral Director: After this completely filled in by the funeral di	Me	29b. Signature and title of certific	ər			29c. Lice	nse number		29d. Date signed	(Month, Day, Year)
,			1/1000		/			H26154		12/2	22/2004
	2		30. Name and address of person	who completed cause of	death (Item	1 23a) (Type,	Print)				
	U		P. Daniel Mil	ler D.O.			res Driv	e, Oakl	and, Md. 2	21550	
	Sta Registr		31. Date filed (Month, Pay Year	3 2004 32. Regist	rar's Signa	ture	di ²				
	riegisti	पा		100	国	1/26 4	Marion a Stell -				

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) DECEMBER 1 Day 14 **Physician** EMMA IONE VINCENT 2004 5:45 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M **XX**F Director 214-16-2422 83 Dec. 22, 1920 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State r than "natural", or itams 23a or 28e-f show the Medical Examinar must be notified at 1 Yes XXNo Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 9337 White Rock Avenue United States Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify 3 N Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 9th Homemaker Own treumetic avant, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leona Grace Iser ပ John Edward Staggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 | Betty Jane Witmer, daughter 9337 White Rock Avenue Frederick, Maryland 21702 item 2. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department or Importent: If any injury or = 5 ' 4 ☐ Donation 5 ☐ Other (Specify) Brook Hill Cemetery 12/18/04 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Rart. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician CONGESTILE HEART /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Palmmary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Obstroche 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2/ No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home P 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) in by 4 Thomicide after within 24 hours a To the Funarel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 15,2004 D-57796 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lalit Verma. West 7th Street Frederick, MD 21701 MD31. Date filed (Month, Day, Year) 32. Regist 's Signature State DEC 1 7 2004 b Registrar

State of Maryland / Department of Health and Mental Hygiene 004 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DECEMBER 13 2004 9:00AM M PETER FLAGG WELTY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON TALBOT 7397 BRETT ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 6 1943 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F MARYLAND 61 Director 216-38-8776 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other treumatic event, the Medical Examinar must be notified at Yes 2□No Directo MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 7397 BRETT ROAD 21601 USA or items 23a ifiled within 72 hours after death I Hygiene.

other then "naturel", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No WHITE Specify. Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry WASTE WATER Elementary/Secondary (0-12) College (1-4or 5+) 12 0 ASST. SUPERVISOR TREATMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi of Health and Mental H fitem 27 is marked otl Be GEORGINE MORRIS LOUIS S. WELTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY S. WELTY/WIFE 7397 BRETT ROAD EASTON, MD 21601 Pages 1 and 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 12-14-2004 STEVENSVILLE, MD 21. Signature of Funeral Fervice Licensee 22. Name and Address of Facility 111 FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician renal 6000 Cavinona Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate and the sequence of Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 🕅 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

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completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 047232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY DESHIELDS M.D. 509 IDLEWILD AVE. EASTON, MD 21601 31. Date filed Month, Day, Year) 32. Registrar's Signature State

Registrar

Maryland 21215-0036

PETER timore,

Box 68760

P.O. |

Records,

Division of Vital

			For 1_ State	State of Mary	and / Depa		lealth and	d Mental Hy	giene	4 41712
			Registrar		001	tineate of	Death	2. Date of Dea	Reg. No."	3. Time of Death
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	/Medic			I. Waugh					er 30,200	
	Examin	ier	4a. Facility Name (If not institution, give			4b. City, Town, o			4c. County of D	
			1603 Robert Lewi	s Avenue			narlboro		Prince G	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday) 36 Yrs.	If Under 1 Year Months Days		lin. 8. Date of Birt	h y, Year) 9.1	Birthplace (State or Foreign Country)
1	Director		143-10-0030	JM 223F	Yrs.			Aug.6,	1918 G	eorgia
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo					10d. Inside City Limits
	aryta Bhov	<u>.</u>	·							1 1 Yes 2 No
	Ba-f	cto	MD Prince Ge	orge's	Upper M	arlboro				1 1 1 1 2 2 1 1 1 1 1 1
	or 2	Sire	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a	by Funeral Director	1603 Robert Lew	is Avenue		20)772		U	SA
	sue sue	nei	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No- lerto Rican, etc.)	14. Race - A Black, W	merican Indian,
9	or tt	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 21☐ No If Yes, Give		1 ☐ Yes 🌠 No		,	Specify:	
21215-0036	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or ttems 23a or 28a-f show ther, fre Medical Examilraer such be motified at		3€ Widowed 4 Divorced	Year or Dates:		12.03 22.00	Dipoony.		Зреспу.	Black
5-0	72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occur kind of work done DO NDT use retire	oation	warkina	16b. Kind of Busine	ss/Industry
2	Page 1	pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NDT use retire	d)			
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b	oth vent	Be (17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle,	Maiden Sumame)	
a	Menta Menta Med Mic e	To E	Bennie M. Foye				Rosa	Bell Foye	9	
Maryland	s 1 and 2 should be filed within 72 hours efter death with the Marylan f Health and Mental Hyglene. Item 27 Is marked other than "naturat", or items 23a or 28a-f show tiem 27 Is marked other than "naturat", and the indiffied at		19a. Informant's Name/Relationship (T)	vpe, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Numbe	er, City or Town, State	e, Zip Code)
	and 2 ealth a n 27 Is		Dyann Waugh - D	aughter	4004	Kennedy S	Street	Hvattsvil	le, MD 20	781
ā,	Health Health tem 27 other tra		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of		Date	20c. Location - City	
٥	nt of nt of t; If i		1 ☑ Burial 2 ☐ Cremation 3 ☐F	Removal from State		matory or other pla Cemetery		2/7/04	Camden,	M T
Baltimore,	permit. Peges 1 a Department of Hes Importent; If item any injury or othe		* 4 □ Donation 5 □ Other (Specify) 21. Sign of Fundal Service Licens							
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	402 40		Jagas W	llung					nington, D	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line.	death. Do not en	ter the mode of dyli	ng, such as card	liac or respiratory ar	rest,	Approximate Interval Between Onget and Death
	Physician		Immediate Cause (Final disease or condition	a End Stage	Alzheim	er's Dise	ease			12 Veaus
	/Medical		resulting in death)	Due to (or as a cor						
	Examiner	R.	Cartinatia Mid list conditions	b						,
		ner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	rsequence oi):					
	cuted id ansi	E	Cause (Disease or injury that initiated events	C.						
ć	be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a con	nsequence of):					
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ŏ	cert nding	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr					23d. Date of	delivery
ă	atte atte I for	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time		□Ectopic pregnanc: □ Other (specify) _	у		Month	Day Year
0	the d	Physician/Med	1 Yes 2 No 9 Unknown	9□ Unknown						
4	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th		Part II. Other significant conditions co	ntributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contribute	e to the cause of death?
Records,	signed d be det	1 by						1 🗆 🗅	/es 21 ⊘ No 3□	Probably 4 Unknown
0	w require been signal	Completed							I	
ec	e law has b	p d						24a. Was autop	sy prior	autopsy findings available to completion of cause of
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Vital	Physicien: The this certificate ral director, page	Be (25. Was case referred to medical examiner?				26. Place of I	Death (Check only o	ne)	
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J Of			27. Manner of Death TXXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c, Injui	ry at rk?	28d. Describe h	now injury occurred	
0	Attending r death. ector: After by the fune	atle	2 Accident investigation			M 1	Yes 2 □ No			
Division	Atte	ific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, st	reet, factory, office		28f. Location (S City or Tox		Rural Route Number,
	el or s afte il Dir d in	Certification:	4 Trombled	Dalidwig, oto. (5)	Journey			0.ty 0. 1 0.t	vii, ciato)	
	splt		29a. Certifier 1 Certifying Phy	rsicien: To the best of my	knowledge, deat	h occurred at the ti	me, date and pl	ace, and due to the	cause(s) and manner	as stated.
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Exam	iner: On the basis of exa A and manner stated.	mination and/or in	vestigation, in my	opinion, death o	ccurred at the time,	date and place, and	due to the cause(s)
	lo th	Me	200. Signatore and title of certifier			K ²⁹ c. Licens	se number		29d. Date signed (Me	onth, Day, Year)
	- 3 - 0	/	DURAL MILLIAM	HUM >		1700	1273	12 1	December	6,2004
0	(0)	1	30. Name/and address of person who c	ompleted squee of dooth	(Item 22a) /T		-	1	Secember	0,4007
KI	8)		Dyann Waugh, MD	4004 Kenn			tevilla	MD 20791	1	
		1	31. Date filed (Month, Day, Year)	32 Registrar's S		cc, myaci	COATITE	, 10/61		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6 2004 10:30 A Annie R. Wright December /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Thomas More Nursing & Rehab. Ctr Hyattsville Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 □ F Yrs. Director 577-46-6354 Georgia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or itams 23a or 28a-f ahow event, it is Medical Exercit at must be notified at 1 X Yes 2 ☐ No Director Maryland Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7726 Pennbrook Place 20785 United States Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☑ Divorced American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retings), S. Headquarters 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th U.S. Marine Corps. Government permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event, 90029. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Artie Reid Laura Mae Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1200 - 34th Place, S.E. Wash., DC Catherine Richardson - POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery |12/9/2004 Suitland, MD 22. Name and Address of Facility 21. Signature of Fyneral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsi riuk /Medical Due to (or n a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Orecase or njury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed; 1 ☐ Yes 2 ☐ No 1 Tes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Varing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☐ No Certification: To 3 DOA 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation nours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12.06.2604 allean cause of death (Item 23a) (Type, Print)

State Registrar 3503

31. Date filed (Month, Day, Year) DEC 1 0 2004

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			Hallot Cate Nutsing										hplace (State or Foreign untry)		
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	how		10a. State 10b. County		10c. City, 1									10d. Inside City Limits 13☐ Yes 2 ☐ No	
	be filed within 72 hours after death with the Maryland stal Hygiene. Ind other then "natural", or fleme 23s or 28s-f ehow event, the Medical Examiner must be notified at	Director	MD Montgom	ery	Silv	er Sp	rings								
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		nue	11. Marital Status	Armed Force	12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto in 1 ☐ Yes 2 ☑ No Specify:			, Puerto Ri	rry Yes or No ican, etc.))-	14. Race - American Indian, Black, White, etc.		
36	rs aft	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give									Specify: Black		
21215-0036	hour	Completed by Funeral	15. Decedent's	Education		16a. Dece	dent's Usua	al Occup	ation			16b. K	(ind of Business/		
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212	d with	E O	12th	Conlege (1 4)	5,5,7	ŀ	Iomema	aker					Private		
	e file al Hy othe vent,	Bec	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name (First, Middle,	, Maider	Sumame)		
<u>a</u>	permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "any injury or other treumatic event, the Magone.	2	Morton Washingto	n					Mary	Was	hingt	on			
Maryland			19a. Informant's Name/Relationship				•						or Town, State, 2		
	and ealth n 27		Cassandra Grant/	<u>Daughter</u>					Court				oring, M		
Baltimore,	of H of H if ite		20a. Method of Disposition 12 Burial 2 ☐ Cremation 3	☐Removal from Sta	ate cem	etery, cre	osition (Nan matory or o	ther plac		Da			ocation - City or	Iown, State	
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<u>,</u>	be execul ician and burial-trar	Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):												
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Вох	death certifical e attending phy d for use as th	N/u	IF FEMALE: 23b. Was decedent pregnant 1								23d. Date of del				
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S	Attending r death.	fica	2 Accident investigation 3 Suicide 6 Could not be determined eletermined 28e. Place of Injury. At home, larm, street, factory, office 28f. Location (Street)								t and Number or Aural Route Number,				
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	To the Hospital or Attendity within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	XIALO	XL		29	c. Licens	e number			29d. Da	Date signed (Month, Day, Year)		
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n/	(2)		30. Name and address of person w					0 to 1	ada '	WID OO	Q 1 <i>I</i> .				
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	1	For State Registrar	State of Mar	yland / Dep		lealth and	Mental Hyg	_															
Physician /Medical Examiner	1	t. Decedent's Name (First, Middle, Last) Helen Ralston Wood ta. Facility Name (If not institution, give s	4b. City, Town, o	r Location of Deat		Day Yea er 9, 2004 4c. County of De	5:20 A ^M																
Funeral Director		Casey House 5. Social Security Number 349-24-0232 6. Sex	(In yrs. last birthday) 74 Yrs.	Rockvil If Under 1 Year Months Days			Birth Day, Year) Birth Country 9. Birthplace (State or Foreign Country)																
a-f show	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montgomer		Rockvill					10d. Inside City Limits 1 ☐ Yes 2 🕅 No														
er death v items 23s		10e. Street and Number 4613 Brad Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 ☐ Yes 2 No If Yes, Give		lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)	Black, W	ace - American Indian, lack, White, etc.														
in all y failed within 72 hours attended should be filed within 72 hours attended the and Mental Hygiens in seturel; or its marked other then "neturel; or treumatic event, the Medical Examination of To Be Completed by F		15. Decedent's Educ (Specity only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired naker	during most of wo	rking	16b. Kind of Busines Own Home	s/Industry														
12 should be filed within and Mental Hygiene. 7 is marked other then irrenmatic event, the Mac							me (First, Middle, M Jacobson ural Route Number		, Zip Code)														
permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other treu once.		Robert Woods, Spou	USE	20b. Place of Dispresentery, cree Ft. Linco	Brad Councisition (Name of matory or other place) oln Crema 2. Name and Addre	tory 12/	ville, Ma Date 13/2004 Simple Tr	ryland 20 20c. Location - City Brentwood ibute	853														
Physician /Medical Examiner	5	23a. Part1. Enter the dilease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	Acute Ce Due to (or as a		ter the mode of dyir	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death 4 days 4 weeks														
ysicia e bui	Physiclan/Medical Examin	cal Exa	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):																		
77 00 1-			nysiclan/Med	hysiclan/Me	hysiclan/Me	hysiclan/Me	hysiclan/Me	nysiclan/Med	nysiclan/Med	ıysiclan/Med	nysiclan/Med	nysiclan/Med	hysiclan/Me	hysiclan/Me	hysiclan/Me	hysician/me	nysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetat death 3	□Ectopic pregnancy □ Other (specify) _	1	
w requires that the been signed by the should be detached.	2	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.							obacco use contribute to the cause of death? 'es 2 双 No 3 □ Probably 4 □Unknown														
	To B	25. Was case referred to medical	24a. Was al autops perform 1 Yes 2	y prior to completion of cause of death? 2¼ No 1 □ Yes 2 □ No																			
thys To		examiner? 1	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 Number 1 Yes 2 Number 1 Nu			ler: 4 □ Nursing H y at k?	4 Nursing Home 5 Residence 28d. Describe how i		e 6 MOther (Specify) Hospice injury occurred														
oltel or Attending Purs after death. In a Director: After the fine of the other of		3 Suicide 6 Could not be determined					City or Town	Rural Route Number,															
To the Hospitel within 24 hours a To the Funerel Completely filled	Medica		sician: To the best of ner: On the basis of e and manner state	xamination and/or in		pinion, death occi	urred at the time, da		ue to the cause(s)														
4		30. Name and address of person who co	045	De	ecember 9,	2004																	
State Registrar	2	Philip Henjum, MD, 31. Date filed (Month, Day, Year) DEC 13 200	32. Registrar		sparks		Maryland	20832															

			1 - For State Registrar	State of M	aryland / De	epartmen Pertificat			and M		giene Rag. No.	nni.	417	16
	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year									3. Time of 12:00	M	
	/Medic Examin		May Whitley 4a. Facility Name (If not institution, give	street and number,)	4b. City,	Town, or	Dec. 9, 2004 1						
			8101 Connecticut A	Avenue #N3	302	Chev					Mo	ontgome	ry	
	Funeral Director		5. Social Security Number 6. St 248 • 16 • 1587	9X 7. Aq □M 2∱2 F	ge (In yrs. last birtho 89 Yr	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da Mar • 15	y, Year)	9. Birth Col 915 Caro	nplace (State country) OUT!	r Foreign 1
			Usual Residence of Decedent		40- 0it T					2.44.	, ,	, 13		
	arylar show	7	10a. State 10b. County		10c. City, Town o								10d. Inside Ci	•
	The M	Funeral Director	MD Montgom 10e. Street and Number	ery	Chevy	Chase 10f. Zip	Code				10a Citi:	zen of What Co		
ž	ms 23a or 28a-f show		8101 Connecticut	Avenue #N	302	701.24		0811			USA		unity :	
		nera	11. Marital Status	12. Was Decedent Armed Forces'		13. Was Deced			gin? (Spe	cify Yes or No		14. Race - Amer		
٥	or Ite		1 X Never Married 2 ☐ Married	1 ☐ Yes 2 🕅	No	1 ☐ Yes		Specify:	, ruelto r	nican, etc.)	t	Black, White Specify: Wh		
3-003e	ural',	d by	3 Widowed 4 Divorced											
-612	nin /2 h	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/life. DO NOT use retired)								ndustry			
7	ed wit /giena er tha	Con		1		omemake	er					wn Home		
and	avani	Be	17. Father's Name (First, Middle, Last) Northen Miller							(First, Middle, Stone		Sumame)		
<u> </u>	nould Marke marke	2	19a. Informant's Name/Relationship (7	Type, Print)	19b. N	lailing Address	(Street a					Town, State, Z	ip Code)	
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Beginner and It is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinat must be netlified at once.	1 3	Jim Earnest / Son			5 Green					-	20817	,,,	
ē.			20a. Method of Disposition	D	20b. Place of D	isposition (Nar	ne of ther plac	e)	Da	ate	20c. Lo	cation - City or 1	Town, State	
Ĕ			1 Surial 2 ☐ Cremation 3 ☐ 1 Donation 5 ☐ Other (Specify	()	Rock Cr	eek Cer	nete	ry De				ington,		
Baltimore,			21. Signature of Funeral Service Licen	Sugar						-		s Sons 20016	Inc.	
	Medical physician and physician and physician transit sthe burial-transit		Willburg K, Durgy 5130 Wisconsin Ave. N.W. WDC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											e ween
F			Immediate Cause (Final disease or condition Renal Failure Onset and Deat 5 years										Death	
			resulting in death)	,	a consequence of)									
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nditions, mediate b. Atherosclerosis Due to (or as a consequence of):										
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	g c										
Ď,			resulting in death) Last Due to (or as a consequence of):											
9/8	cate b ohysic the bi	dicai	•	d										
ρ X	the death certificate y the attending phys iched for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy						2	3d. Date of deli	verv	
POX	death a atter d for u	Physician/M	in the past 12 months? 1 □ Yes 2 🎛 No	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							Month	,		
י ב	at me by th stache	hys	9 Unknown	9□ Unknown										
S	w requires that the debase signed by the should be detached	by	Part II. Other significant conditions c	, , , , , , , , , , , , , , , , , , , ,								ibute to the cause of death? 3 ☐ Probably 4 ☑Unknown		
ecord	peen	Completed								24a. Was			topsy findings	
He	Ine law sate has b page 2 sl	dwc								autop	rmed?	prior to o death?	ompletion of ca	ause of
	certificate has rector, page 2	0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only o	2 X No ne)	1 Li Yes	2 No	
>	S S S	To B	examiner? 1 □ Yes 2 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Outp	atient 3 DC	A Othe					Other (Spec	ify)	
0	ding Fn h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?											
SIO	death death tor: /	icati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 200 River At home form street feature of the could not be							ral Routa Num	har			
DIVISION	after d Dirac	ertification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be de								rai Houte Num	ber,		
	within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	ledical C	29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s))	
		Med	one) 29b. Signature and title of certifier)	and manner s	tated.	290	. License	e number			29d. Date	signed (Month	, Day, Year)	
,			MIX	stips 1	ND		D616	65				ber 10,		
ت	*		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Restifo, M.D. 3301 New Mexico Ave. N.W., Washington, D.C. 20037											
			Mary Restifo, M.D. 31. Date filed (Month, Day, Year)		ew Mexico	A			shing	gton, D	.C.	20037		
N.	Sta Registr		DEC 13 2		Leve L	9 So	ark.	21						

	an	Decedent's Name (First, Middle, L					2. Date of D	eath 12	2-23-20	04 3. Time of De
/Medic	al	Michael Rober 4a. Facility Name (If not institution, gi			4h City Tou	vn, or Location of De	DEC. 2		2004 County of De	120,10
Examin	er	FREDERICK MEMORI			FREDE		Jalli		REDERI	
uneral			Sex 7. Age (II	n yrs. last birthday)	If Under 1 Y	ear If Under 24 h	Hrs. 8. Date of B			Birthplace (State or F Country)
irector		215-78-9111 Usual Residence of Decedent	1 M 2 □ F 4			ays Hours N	April 4	, 19	063 Ma	ryland
a-f show	ctor	10a. State 10b. County Maryland Freder		Dc. City, Town or Lo Brunswi						10d. Inside City I 1 X Yes 2
23a or 28 st be no	al Dire	10e. Street and Number 122 Fiona Way			10f. Zip Co 21	^{de} 716		_	tizen of What	Country?
Important if them 21 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at 90ce.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Al Black, W Specify:	merican Indian, hite, etc. white
an "natu Medical	npietec	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual O kind of work d DO NOT use n	ccupation one during most of etired)	working	16b. K	ind of Busine	ss/Industry
t, the		10		Mec	hanic_				omotiv	'e
even	Be	17. Father's Name (First, Middle, Las	t)				Name (First, Middle	e, Maiden	Sumame)	
narke	٢	Frank H. Wachter 19a. Informant's Name/Relationship	(Time Print)	10h Mailie	ng Addrona (Si		y Fogle	has City	Town Chair	7in Code)
7 Is r traur		Kimberly Wachter			_	reet and Number or Way, Brun		-		716
tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name o	of .	Date	_		or Town, State
y or		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	сөтөtөгу, cren Frederick			/26/04	Fred	lerick	Maryland
injur		21. Signature of Funeral Service Lice				ddress of Facility S				
any is		1 X1291	6	16	21 Ono:	ຣ ssumtown	tauffer i Pike. Fre	deri	ck. Ma	e ryland 21
attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co					· · · ·		
physics the	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregri				23d. Date of o Month	delivery Day Yea
y the ached	Š		contributing to death but n	ot resulting in the ur	nderlying caus	e given in Part I.		tobacco i		to the cause of dea
y the ached	ed by Phys	Part II. Other significant conditions Cocaine usage			_		_			
been signed by the should be detached	Completed	Cocaine usage					24a. Wa auto perf Yes	opsy ormed? 2 \(\sum \) No	prior t death	autopsy findings ava o completion of caus ? es 2 \(\sum \text{No} \)
been signed by the should be detached	Be Completed	Cocaine usage 25. Was case referred to medical examiner?	Hospital: SE Inoction		* 2 DOA	04	24a. Wa auto perf Yes Death (Check only	opsy ormed? 2 \(\sum \) No	prior t death	o completion of causes es 2 No
fler this certificate has been signed by the neral director, page 2 should be detached	To Be Completed	25. Was case referred to medical examiner? 1\(\begin{align*} \text{Yes} & 2 \subseteq \text{No} \end{align*} 27. Manner of Death 1 \(\begin{align*} \text{Natural} & 5 \subseteq \text{Pending} \end{align*}	28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatien 28b. Time of Injury		04	24a. Wa auto perf Yes	opsy ormed? 2 \(\sum \) No one) idence	prior t death	
fler this certificate has been signed by the neral director, page 2 should be detached	To Be Completed	Cocaine usage 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c.	Other: 4 Nursin	24a. Wasuti performed yes 28d. Describe	opsy ormed? 2 \(\sum \text{No}\) one) idence how injure	of Number or	o completion of caus? es 2 □ No pecify)
fler this certificate has been signed by the neral director, page 2 should be detached	Certification; To Be Completed	Cocaine usage 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Yes 1 Pending investigate 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	28a. Date of Injury (Month, Day Ye	28b. Time of Injury - At home, farm, stri Specify) Ty knowledge, death amination and/or in	M eet, factory, of	Other: 4 Nursin	24a. Was auto part Yes Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	ppsy ormed? 2 \subseteq No one) idence how injuit (Street arrawn, State	6 □Other (S) ry occurred and Number or a)	o completion of caus? es 2 No pecify) Rural Route Number as stated.
this certificate has been signed by the al director, page 2 should be detached	To Be Completed	Cocaine usage 25. Was case referred to medical examiner? 1\(\tilde{\ti}	28a. Date of Injury (Month, Day Ye building, etc. (statement) 28e. Place of Injury building, etc. (statement) hysician: To the best of mininer: On the basis of ex	28b. Time of Injury - At home, farm, stri Specify) Ty knowledge, death amination and/or in	M eet, factory, of	Other: 4 Nursin	24a. Was auto part Yes Death (Check only g Home 5 Res 28d. Describe 28f. Location City or To	ppsy ormed? 2 No one) idence how injuit (Street arrawn, State cause(s, date and	6 Other (S) ry occurred and Number or and number or and place, and d	o completion of caus? es 2 No pecify) Rural Route Number as stated.

				State of Marylar					iene 20 0 1.	1 1 7 1 0
			For State Registrar		Cei	tificate of	Death	R	eg. No.	41/18
	Dhariai		1. Decedent's Name (First, Middle, Last)					Date of Dea Month	Day Year	3. Time of Death
	Physici /Medic	al	Braden Lee Work					Decembe:	r 14, 2004	5:13 P M
	Examin	er	4a. Facility Name (If not institution, give stre			4b. City, Town, o Walkers	Location of Death		4c. County of Dear	
_			9403 Highlander B1 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	O Bird	thplace (State or Foreign buntry)
	Funeral Director			1 2□F 69	Yrs.	Months Days	Hours Min.	Jan. 13	, 1935 Wasi	nington, D.C
	P		Usual Residence of Decedent 10a. State 10b. County	100 Ci	ty, Town or Lo	cation				10d. Inside City Limits
	show	-			alkers					1 ☐ Yes 2 ☒ No
	the M	Director	Maryland Frederick 10e. Street and Number		aiker 5	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	3a or	<u>a</u>	9403 Highlander Blv	d.		2179:	3		United S	tates
	death	Funerai		Was Decedent Ever in U	J.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or its	y Fu	1 ☐ Never Married 2 ☒ Married	1 X Yes 2 No 195)/-	1∐Yes 2150TNo			Specify: Wh:	
Ö	be filed within 72 hours after death with the Maryland hat hygiene. Id other than "natural", or itams 23e or 28e-f show event, the Mcdiral Examinar must be mailled at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa		959 16a. Deces	dent's Usual Occup	ation		16b. Kind of Business	Industry
15	in 72 n "na	plet	(Specify only highest grade of Elementary/Secondary (0-12)		(Give	kind of work done DO NOT use retired	during most of work	ing		•
212	d with giene ar tha	Completed	10	College (1-40/ 54)	Press	man				Publication
nd	oe filed vall Hygie d other i	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name			
yla	shoutd be and Mental marked o umatic eve	ဥ	Allen Work	04-1	105 Maille	- Address /Street		Windson	r, City or Town, State, I	Zin Code)
Mar	d 2 shoth and 7 is m		19a. Informant's Name/Relationship (Type Beverly S. Work / W			•			7ille, MD 2	
ē,	s 1 and 2 should f Health and Men itam 27 is marke othar traumatic		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place			20c. Location - City or	
Baltimore, Maryland 21215-0036			1 ⊠ Burial 2 ☐ Cremation 3 ☐ Rer `4 ☐ Doπation 5 ☐ Other (Specify)	noval from State		Mem. Gar		- 1	Frederick,	Maryland
atti	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licensee	1101	R ²	Name and Addre	Fulferal s	ervices	, Skkot Cod	ly P.A.
<u> </u>	88 2 2 8		1						ederick, MI	
			23a. Parti. Enter the disease of complica shock or heart failure. List only one	tions that caused the dea cause on each line.	th. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ex6	13,60	100	5 m 011 C	211 69	10-13	14 000
	Examiner			Due to (or as a consec		,				
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						
	cuted nd .ransit	Examiner	that initiated events							
760,	ate be executed ysician and he burial-transit	i Ex	resulting in death) Last	Due to (or as a consec	quence of):					
6876	cate b physic the b	edicai	d.							
9 x 6	leath certificate attending phy I for use as the	//Me	IF FEMALE: 230. Was decedent pregnant	. If yes, outcome of pregn					23d. Date of de	livery
Box	death e atter d for t	Physician/M	in the past 12 months?	1 Live birth 2 Feti 4 Pregnant at time of		Ectopic pregnance Other (specify)	y		Month	Day Year
P.0	at the de by the	hys	9 □ Unknown	9□ Unknown				00- Dida-	bacco use contribute to	the source of death?
	The law requires that the death certifical the has been signed by the attending phypage 2 should be detached for use as the	by	Part II. Other significant conditions contr	buting to death but not re	sulting in the u	nderlying cause giv	en in Part I.			robably 4. Unknown
Vital Records,	w require been sig should b	Completed	COPD					24a. Was a		utopsy findings available
Rec	has b	ldm						autop: perfor	sy prior to death?	completion of cause of
tal		e Co	25. Was case referred to medical				26. Place of Deat		2 No 1 ☐ Yes	2 No
	Physician: The lav this certificate has ral director, page 2	To B	examiner? 1 ☐ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ott			ence 6 Other (Spe	cify)
n of	o → @		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo		28d. Describe h	ow injury occurred	
sio	ittandii death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	On Plans of Injury At h	toma form of		Yes 2□No	28f Location /S	treet and Number or R	ural Route Number
Division	after d Direct	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	еві, тасіоту, оптсв		City or Tow	n, State)	arai rioate reambor,
	Hospital or Attand 24 hours after death Funaral Director: lely filled in by the		29a. Certifier 1 Certifying Physic	cian: To the best of my kn	owledge, deat	h occurred at the ti	me, date and place,	and due to the o	ause(s) and manner a	s stated.
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	one)	r: On the basis of examin and manner stated.	ation and/or in					
	To ths within 2 To tha complet	Σ	29b. Signature and title of certifier	7		29c. Licens			29d. Date signed (Mont	
•				a me		DIY	676	1	Jec. 16	2004
			30. Name and address of person who com		m 23a) (Туре,	a no	3 51	Fred.	Dec 16	21710/
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		B - M 0				
	Regist		DEC 17 20	U4 Leges	S. A	GORES I				

			1- For Amend Iter	n 26 per bl	/larylan	d, 0492 Cei	Tyosa Tificat	t of Ho	ealth a	and M	ental Hy	giene	200.	1.	1.1710
			Decedent's Name (First, Middle								2. Date of De	ath		£ c ja	3. Time of Death
	Physici /Medi		Joseph C.	. Williams							Month Decemb	er !	5 20	oar 04	11:33 ^M
	Examir		4a. Facility Name (If not institution,	give street and number	er)		4b. City,	Town, or	Location				County of I		
			Southern Mary				Milledon		Clin						orge's
	Funeral Director			6. Sex 7 1 □XM 2 □ F		last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)			ice (State or Foreign y)
			578-58-3445 Usual Residence of Decedent		59					ll	Apr. 3	0, 19	945	Was	h., DC
	anyfan show	_	10a. State 10b. County			y, Town or Lo	cation							10	d. Inside City Limits
	88-13	ecto		ce George's					er Ma	ar1bo	ro				1 XYes 2 No
	a or 2	宣	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of Wha	it Counti	y ?
	death ms 23	Funeral Director	10903 Wad	12. Was Decede	nt Ever in U.	S. 13.1	Was Deced	lent of His		0772 igin? (Spe	crfy Yes or No Rican, etc.))- 1	14. Race - /	America	States n Indian,
9	or Ite	교	1 ☐ Never Married 2 ☐X Marrie	Armed Force ad 1 Tyes 24 If Yes, Give							Rican, etc.)				ican
5-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-1 show Jical Exter inter routhed	d by	3 Widowed 4 Divorced	Year or Date:	s:		1 Yes 2		Specify:				Specify:		rican
15-	n 72 h	Completed	15. Decedent (Specify only highes	s Education t grade completed)		16a. Deced (Give	dent's Usua kind of wor DO NDT us	il Occupa k done di e retiredi	ition <i>furing m</i> os	st of working	ng	16b. Kir	nd of Busin	ess/Indu	istry
2121	filed within 7 Hygiene. other than "r ent, the Meu	ошо	Elementary/Secondary (0-12) 12th	College (1-4d	or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				ician			Gov	vern	ment
	al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, L	ast)							(First, Middle	, Maiden :		V C I II	
ylaı	Menti Menti arked aric s	To	Josepl	n C. Willia	ıms, S								Thom		
Maryland	12 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, tre Me.		19a. Informant's Name/Relationsh Beverly S. W:		U4 fo						Route Numbi				
	1 and Healt em 2		20a. Method of Disposition	IIIIIallis –	20b. P	lace of Dispo	sition (Nam	ne of	1		Marol		cation - City	207	
Baltimore,	ages ant of tt: If it y or o		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		te C	emetery, crer Linco	natory or of	her place	1	12/10	/200/				
altii	permit. Pag Department Important: I any injury o		21. Signature Funeral Service L		1		. Name an				ewart		Brenty cal Ho		, PID
m	Depa Impo any id		10hul	· News	WI		4001	Benn	ing I	Rđ.,	N.E. W	ash.,	DC :	2001	9
			23a. Part1. Extended the disease, or of shock, of heart failure. List of	complications that caus only one cause on each	ed the ath	Do not ent	er the mode	of dying	g, such as	cardiac or	r respiratory a	rrest,		1	Approximate nterval Between
	Physician		Immediate Calle (Final disease or condition resulting in death)	-a Lun	5	Can	cev-							(Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or a	as a consequ	uence of):								-	
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6											
00	e exerian ar	i Ex	resulting in death) Last	Due to (or a	as a consequ	uence of):									
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai		d										-	
9 x	death certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	ncv						2	2d Data of	dalisaas	
Box	death atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 ☐ Fetal at time of de	death 3	Ectopic pre Other (spe					-	3d. Date of Month	,	ay Year
P.0.	t the by the tacher	hys	9 Unknown	9□ Unknown											
	res that the de signed by the a be detached f	by	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the ur	nderlying ca	use giver	n in Part i.	•					cause of death?
ord	w require been sig	eted									1 🗆 1	Yes 2	No 3] Probat	bly 4 ElUnknown
Records,	The law	Completed									24a. Was autop	an osy ormed?	24b. Were	to comp	y findings available detion of cause of
Vital			25. Was case referred to medical								1 ☐ Yes	2 XNo	1 🗆 '	Yes 2	□ No
<u>S</u>	Physician: this certificatal director, p	To Be	examiner?	Hospital: 1 ☐ Inpa	tient 22	ER/Outpatien	t 3 DO	Other			(Check only only only only only only only only		Other (Specify)	
n of	ter thi		27. Manner of Death	28a. Date of in		28b. Time of		3c. Injury			8d. Describe h			эрсону	
Siol	Attending r death. ector: After by the funer	catic	2 Accident investiga	ation		,,	М		es 2 🗆 i						
Division	l or Att after d Direct I in by	Certification;	3 Suicide 6 Could no 4 Homicide determin	and 288. Place of	njury - At ho etc. <i>(Specif</i> y	me, farm, stre	eet, factory,	office		2	8f. Location (5 City or Tox	Street and vn, State)	Number o	r Rural F	Route Number,
	ospital hours a uneral ly filled		29a. Certifier Certifying	hysicien: To the be	st of my know	wledge, death	occurred a	t the time	e date an	d place, a	nd due to the	Causa(s) a	and manne	r as etat	ad .
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only one) 2 Medical E	xeminer: On the basis and manner	of examinat	ion and/or inv	estigation,	in my opi	inion, dea	th occurre	d at the time,	date and	place, and	due to th	ne cause(s)
	To the To the comp	M	29b. Signature and title of certifier	/			29c.	License	number			29d. Date	signed (M	onth, Da	12/06/04
	P		14/1/	~			1)	005	5740	18-		1	6/20	OY,	12/00/04
K	(5)		30. Name dad as fp rso w	no completed cause of	death (Item	23a) (Type, I	Print)		11.	W.	1/0 1	21	175	C	Medical Property
	Sta	te_	31. Date filed (Month, Day, Year)		trar's Signat		70	Crya	C 13	_14	va	00	177		MAD
	Registi		DEC 1 0 2			Spa	de								

			1 - For State Registrar	State of M	Maryland / Dep <i>Ce</i>		of Healt of Dea			jiene 2 (104	41720
	Physic /Medi		1. Decedent's Name (First, Middle, Last, Allie E. Zeigle						2. Date of Deat Month Dec.	Day 14, 20	Year 04	3. Time of Death 9:50 P. M.
	Examir		4a. Facility Name (If not institution, give 7505 Planters Lan	e				ersburg			lontgo	omery
	Funeral Director		5. Social Security Number 6. Security Number 1220–42–2871 Usual Residence of Decedent	M 25kF	Age (In yrs. last birthday) 89 Yrs.	If Under 1 Months	Days Hou		8. Date of Birth (Month, Day, April 20	Year)		ace (State or Foreign ry) yland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any njury or other traumatic event. The Medical Examinational Le routing at 2056.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Montgom 10e. Street and Number 7505 Planters Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) William H. Dorsey 19a. Informant's Name/Relationship (Ty Mike Zeigler/ Son 20a. Method of Disposition 1 XBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)	12. Was Deceder Armed Force: 1	16a. Dece (Give life.) 19b. Mailie 2690 20b. Place of Dispo cemetery, cree	was Decede If Yes, specification Was Decede If Yes, specification Was Decede If Yes, specification Work Work Work Work Work Work Work Work	20882 Int of Hispanic y Cuban, Mex No Spec Occupation done during r retired) Interest and Nu. Road, of pr place) Cemet	other's Name e Lyle mber or Rura Mt. A	cify Yes or No-Rican, etc.) og (First, Middle, A. S. S. I Route Number, iry, Ma. ate	Blac Specify 16b. Kind of Bu Own Ho Maiden Sumam City or Town, ryland 20c. Location - Damascu	What Countries State e - America ek, White, et Blace siness/Indu me 2177 City or Tow s, Ma	ck ustry Code) 71 vn, State
	Pnysician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	cations hat causine cause on each	ed the death. Do not ent	6401 Fer the mode Heer Aster	idge R of dying, such	oad, D		. Marvl	and 2	20872 Approximate Interval Between Onset and Death
P.O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con	4☐Pregnant 9☐ Unknown	2 Fetal death 3 at time of death 5	Ectopic pred Other (spec	ify)	art I.	23e. Did tob	Mon		/ Day Year cause of death?
al Records	The law ate has b page 2 s	Completed							1 Yes 24a. Was an autopsy perform 1 Yes 2	24b. W	Vere autops rior to comp eath?	sy findings available pletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of In (Month, D	tient 2 ER/Outpatien jury, ay Year) 28b. Time of Injury injury - At home, farm, streatc. (Specify)	28d	Other: 4 Injury at Work? 1 Yes 2	Nursing Hom 2	Check on one Be 5 Resider Bd. Describe how Bl. Location (Strictly or Town,	nce 6 Othe w injury occurre	ed	Route Number,
J	e Hospital 124 hours a e Funeral I letely fillad i	Medical Ce	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the bes er: On the basis and manners	at of my knowledge, death of examination and/or inv stated.	occurred at restigation, in	the time, date my opinion, c	and place, and death occurred	nd due to the car d at the time, da	use(s) and man te and place, a	nner as state	ed. ne cause(s)
l	To the within To the comple	Me	29b. Signature and title of certifier Catalwaleh	rlah			icense numbe	496		d. Date signed		
	10		30. Name and address of person who co Mohammad A. Khalid	, 8630 E	enton Stree		te 700), Silv	er Spri	ng, MD	2091	.0
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	r's Signature	Sport						

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment rtificate				giene 0 0	4	4172	21
Г	Physici		Decedent's Name (First, Middle, George	.ast)	н.		A11e	n	2. Date of De Month Decembe	Day	Year 04	3. Time of E	Death M
	/Medio Examin		4a. Fecility Name (If not institution, g	rive street and number)		4b. City, T	own, or Lo	ocation of D		4c. County	of Death	*	
			Southern Marylan					nton		Prince			
	Funeral Director		224-01-5958	Sex 7. Age 7. Age 93	(In yrs. last birthday, Yrs.	Months		Hours N	Ars. 8. Date of Bir Month, Da Jan	19,1911	9. Birthp Cour V11	place (State or ntry). Cginia	Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					1	0d. Inside City	/ Limits
	ith the Marylar or 28e-f show	ctor	Maryland Prince	George's	U	pper M		oro				1 🗌 Yes	2 XNo
	with the	Dire	10e. Street and Number 58 joyceton Te	~		10f. Zip 0				10g. Citizen of V		ntry?	
	eath w	eral	58 joyceton Te	12. Was Decedent E	ver in U.S. 13.			anic Origin	(Specify Yes or No	o- 14. Race		can Indian,	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumatic event, the Medical Evanther real by multified at	Completed by Funeral Director	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	0	If Yes, specif		Mexican, Po	? (Specify Yes or No uerto Rican, etc.)	Blac	k, White,		.n
21215-0036	thin 72 hours e. en "naturel", Medical Exe	npleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5	(Give	edent's Usual kind of work DO NDT use	Occupation of the Coupation of the Coupa	on ring most of	working	16b. Kind of Bu	siness/Ind	dustry	
	led will lygien her th		6th		Min	er		0 Mathada	Name (Cine Adiedale	Coa1			
Maryland	2 should be filed within ? n and Mental Hygiene. r is marked other then "r reumatic event, Ira Med	Be	17. Father's Name (First, Middle, La George Washi:				"	Unkr (Unkr	Name (First, Middle	eeds	θ)		
Z	should nd Me mark	J.	19a. Informant's Name/Relationship		19b. Mail	ing Address ((Street and		r Rural Route Numb		State, Zip	Code)	
	and 2 sauth ar n 27 is		Norma Madison (Daughter)	7704	Keppe	e1 P1a	ace Cl	Linton, Ma	aryland :	20735	5	
Baltimore,	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	matory or oth	her place)		anuary 4,	20c. Location -			
Ë	: Pages tment of I tent: If its tjury or o		' 4 Donation 5 Dother (Spe	cify)	Harmony				2005	Landove			
Bal	permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tre 2002.		21. Signature of Funeral Service Uni	Funeral Service Licensee 22. Name and Address of Facility Lee Funeral 6633 Old Alexandria Ferry R									735
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition	implications that caused by one cause on each lin	the death. Do not ene.	ter the mode	of dying,		diac or respiratory a	1 4 4	SAC	Approximate Interval Between Anset and De	reen
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):								
		ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):								
8760,	ate be executed thysician and the burial-transit	cal Exar	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):								
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pre ⊒ Other (spe				23d. Dat	e of delive	,	e ar
	uires that signed b Id be deta		Part II. Other significant condition SMALL Part II. Other significant condition	s contributing to death bu	at not resulting in the	underlying ca	use given	in Part I.		tobacco use conti Yes 2 No	ribute to th		ath? nknown
Records,	0 0	Completed by	CANCER C	VF THE	Col	DN				ppsy prmed? c	orior to co death?	psy findings avmpletion of car	vailable use of
ta	icien: Th certificate rector, pag	a)	25. Was case referred to medical				2	26. Place of	1 ☐ Yes Death (Check only			2[] 140	
of Vital	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie				4 Nursir	ng Home 5 ☐ Resi	idence 6 Oth	ar (Specif	у)	
	ding P	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injui (Month, Day	Year) 28b. Time (Bc. Injury a Work?		28d. Describe	how injury occurr	ed		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be Gas Blace of Init	ury - At home, farm, s c. (Specify)	M treet, factory,		es 2 No		(Street and Numb wn, State)	er or Rura	al Route Numb	ier,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edical Ce		Physician: To the best of taminer: On the basis of and manner sta	examination and/or is								
	To the within Fo the comple	Mec	29b. Signature and title of certifier			29c.	License n	number		29d. Date signed	1 (Month,	Day, Year)	93
	(110		V	D)-19	854	5	HEELISE	汉	28, 28	YOU
	(0	Name and address of person w	no completed cause of diagram $(4) - 120^{-1}$	eath (Item 23a) (Type	1708 C	SUR	A.	5 / WAC102	F, Ud	. 2	0602	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	م							

			1 - For State Registrar	State of I		id / Depa		t of H	ealth a					4	1722
E	Physici	an	Decedent's Name (First, Middle, III) ANDREW	EMM E	ETT	ALL	EN			7	2. Date of Dea Month DECEMB	Day	Year 28 200		of Death
	/Medic Examir		4a. Facility Name (If not institution, s	rive street and number			4b. City,		Location o	of Death	IRY LAN	4c. (County of De	1	
1	Funeral Director		218-28-1247	1√2M 2□ F	Age (In yrs. 73	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Aug. 25	h v. Year)		rthplace (Sta Country) larylai	nte or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Ball	timore	10c. Cit	ty, Town or Lo	ocation			Edger	mere				e City Limits Yes 2\(\infty\) No
	h with the 13a or 28e 11 be noti	al Director	10e. Street and Number 3232 Lynch Roa	n d			10f. Zip	Code	212	19			en of What (
920	be filed within 72 hours after death with the Maryland that Hygiene. sd other then "neturel" or items 23a or 28e-f show event, the Medical Examinar must be routiled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force	s? ∃No		Was Deced If Yes, spec		spanic Orig n, Mexican		cify Yes or No- Rican, etc.)	. 1	4. Race - An Black, Wh	erican India	,
Maryland 21215-0036	within 72 ho ene. then "netu he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4d	or 5+)	(Give	dent's Usua kind of wor DO NOT us	k done d	urina most	t of workin)g	16b. Kin	d of Busines	s/Industry	
and 21	I be filed within ntal Hygiene. ed other then event, the We	Be	17. Father's Name (First, Middle, La		S	F.	ire F:	ight	18. Mothe		(First, Middle,	Maiden S	ŕ	lustry	
Maryla	ges 1 and 2 should be f t of Health and Mental F If item 27 is marked of or other treumatic eve	7	Andrew E. Alle 19a. Informant's Name/Relationship Mrs. Barbara ((Type, Print)	Wife	1	ng Address 2 Lyn		nd Numbe	or or Rural	esa Dek Route Numbe Mere, M	r, City or	Town, State,	Zip Code)	1
Baltimore,	Pages 1 and 3 nent of Health out: If item 27 iry or other tru		20a. Method of Disposition 1	☐Removal from Sta	20b. F	 Place of Dispo cemetery, crei	osition (Nam matory or of	ne of ther place	9)	Da	ate 1/2004	20c. Loc	ation - City o	r Town, State	
Baltir	permit, Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lie	_	11.06	12 22	2. Name an	d Addres	s of Facility	V	Home of				TID
Harman Street	Pnysician /Medical Examiner).	23a. Part 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate	a. A Due to (or	sed the death line. CUTE as a consequate as a consequence	h. Do not ent	ter the mode	e of dying	g, such as	cardiac or		rest,		Approxi Interval Onset a	Between .nd Death
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a conseq										
.O. Box 6	at the death certific by the attending pitached for use as I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Feta t at time of c	aldeath 3	∃Ectopic pre ∃ Other <i>(sp</i> e					23	3d. Date of d Month	elivery Day	Year
Δ.	w requires that been signed by should be deta	by	Part II. Other significant condition						n in Part I. PROS				e contribute YNo 3□F		
Il Records,	: The law recate has being page 2 sho	Completed	CA: CHRONIC OB	STRUCTIV						/	24a. Was autop perfor	sy med?	prior to death?	utopsy findir completion s 2 No	ngs available of cause of
of Vital	nyeicien nis certifi I director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death			ER/Outpatier			r: 4□Nui	rsing Hom	(Check only one 5 ☐ Resident	lence 6		ecify)	
Division	To the Hospitel or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	1 Matural 5 Pending investiga 3 Suicide 4 Homicide 5 Pending determin	t be 28e. Place of		Injury ome, farm, sti	М		?` 'es 2 □ N	No	8f. Location (S City or Tow	itreet and		Rural Route f	lumber,
	he Hospit in 24 hours he Funera pletely fille	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be aminer: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	nd due to the o	ause(s) a	and manner a place, and du	is stated.	se(s)
)	To t With To t	Σ	29b. Signature and title of certifier	O M	.D			License	_286				signed (Mor		r)
	107)		30. Name and address of person with POTHURAJU NAG		of death (Iter	n 23a) (Type. SOUTH He	Print) ANOVER	ST	BALT	IMORI	E, MD	21	225	o tile e	
1	Sta Regist		31. Date filed (Month, Day, Year) JAN 0	32. Reg	istrar's Signa		had	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 39 30 2004 une /Medical 4c. County of Death 4a. Fecility Name (I) not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bal MD IVERSITY M N/A University D Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min 1**X** M 2□ F 10, 1952 Director 220-58-6990 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r then "natural", or itama 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Marvland Howard Jessup 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20794 8736 Clemente Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens important: If Item 27 is marked other then "na any injury or other traumatic event, Ita Madic once. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Clerk/Security Restaurant/Bar 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Richard Eugene Barr Joy Williams ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jessup, MD 20794 Kristi L. Stephenson/daughter 8736 Clemente Court 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/03/05 Baltimore, MD Metro Crematory, Inc. * 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisenses

Dawn F. McDonald Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) E) **Physician** /Medical Examiner mth bac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Physician/Medical Examiner the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ 99 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Xnpatient 2 ER/Outpatient 3□ DOA Medical Certification; To After this te of Injury (Month, Day Year) 27. Manner of Dan 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Accident 5 Pending 2 No death. investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Records, P.O. Box 68760. Division of Vital

To the Hospital or Attending Physician: The law requires that the death certificate be executed filled in by the f hours after within 24 hours a To the Funeral I

> State Registrar

DHMH 17 Rev 1/2001

29a. Certifier (Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Alexandra Pratt UT S. Greene 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

St.

18601

Baltimore

29d. Date signed (Month, Day, Year)

MD 2120

121 31

			1 - For State Registrar		artment of Health and I	nt of Health and Mental Hygierge 0 0 4 4 1 7 2 4 te of Death					
I	Physic		1. Decedent's Name (First, Middle, Las	Bacot	2	2. Date of Death Month	Day Year	3. Time of Death			
	/Medi Examii		4a. Facility Name (If not institution, give FUTURE CARE	street and number) Home wood	4b. City, Town, or Location of Death		4c. County of Death				
	Funeral Director		5. Social Security Number 6. Security Number 10 Usual Residence of Decedent	7. Age (In yrs. last birthday Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp 5. Coun	lace (State or Foreign try) (10/11)			
	e Maryland Sa-f show tiffed at	ctor	MD 10b. County	10c. City, Town or L Baltim			1	0d. Inside City Limits 1			
	h with th	al Dire	2700 N. Charles	s St.	10f. Zip Code		Citizen of What Coun	try?			
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alsal Examiner must be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Vivorced		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 In No Specify:	oecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, of Specify: Black	an Indian, etc.			
21215-0036	d within 72 ho piene. r than "natur tt.e Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give	odent's Usual Occupation a kind of work done during most of work DO NOT use retired)	king 16b	Kind of Business/Ind	lustry			
Maryland 2	tould be filed Mental Hygin narked other natic event, II	Be	17. Father's Name (First, Middle, Last)	100,	unk.	ne (First, Middle, Maid					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at any injury or other traumatic event, the Madical Examiner must be notified at any injury.		19a. Informant's Name/Relationship (T) EVA L. FULLER 20a. Method of Disposition 1 Burial 2 Cremation 3	- Granddaughter 56 20b. Place of Disposemetery, cre	osition (Name of matory or other place)	Date 20c.	Location - City or To	21239 wn, State			
Baltimore,	permit. Par Departmen Important: any injury once.		4 □ Donation 5 □ Other (Specify 21. Signatur of Funeral Service Constitution of the s	Ring Men	2. Name and Address of Facility	-05 Ra	ndallstown Acs Balta				
	Pr ysicia n /Medical		23a. Penti Erler the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not en	ter the mode of dying, such as cardiac notic Cordio	or respiratory arrest,		Approximate Interval Between Onset and Death			
,8760,	Examine be executed by physician and burial-transit	l Examiner	Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of):							
O. Box 6	The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year			
٩	quires that in signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacci	ouse contribute to the				
Il Records,		Completed				24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of			
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	0.4	h (Check only one)					
of	ding h. After fune	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Nursing Ho	me 5 Residence 28d. Describe how in					
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street City or Town, Sta	ife)				
	To the Hospital o within 24 hours aft To the Funeral D completely filled it	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exemi	sicien: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as sta nd place, and due to t	ted. the cause(s)			
	To th within To th compl	Me	29b. Signature and title of certifier	R M.D.	29c. License number D47405	1)	ate signed (Month, D				
	1		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type,	Print) Eutaw St. Ba	ltime	MD21	201			
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature	whi						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 17,18 per fh 8839 1-4-05 vt. State of Maryland? Department of Health and Mental Hygiene 11. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month :00 P. M AVID E 200 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTI MORE

If Under 1 Year | If Under 24 Hrs. | 8

Months | Days | Hours | Min. | WILLARD STREET NIA 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign – Country) **Funeral** -28-841 1 MM 2□ F Director AUG. 27,1 Usual Residence of Decedent 10a, State 10b. County "natural", or itema 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits Director 1⊠Yes 2 No MARILAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ø No Specify: Completed by 3 Widowed 4 ☐ Divorced The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Ejementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 6+HGRADE RICK LAVER 17. Father's Name (First, Middle, Last)
Rev. Theodore Bradley 18. Mother's Name (First, Middle, Maiden Sumame) Be - Lisha Fulton ဥ VANDA LICHBETH of Health and M Item 27 is man other traumal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE ADAMS (369040 DAUGHTEN FREDERICK RD BALTO. MD 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 2 c. Location - City or Town, State 0 <u>+</u> 1 Burial 2 Cremation 3 □ Removal from State 20 permit. Page Department of Important: If any injury or KING MEMORIAL PARK 01-03-05 WOODLAWN 5 Other (Specify) 4 Donation 21. Signature of Furn al Service License 22. Name and Address of Facility BROWN JR, FUNERAL HOME TON AVE., BALTO, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ancer, metastatic disease or condition resulting in death) month uno /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the list of the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy jo in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) Day Year ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 4 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 Yes 2 No ဥ 5 Residence 6 Other (Specify) this in by the funeral 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Yeer) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide filled within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN D53590 ung h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 624 NORTH BROADWAY SUDHEM DY, MD RM 609 BALTIMORE MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

JAN 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 200 per in 0839 1 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .30 PM Day Month Krooks **Physician** Mamie w. 20 2004 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMO128 BALTIMORE TOWSON jowsen 1) anor (one If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 X F 90 Director 213-14-9527 Maryland 08/15/1914 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County r than "neturel", or items 23s or 28e-f show the Medical Exerciner must be notified at 1 Yes 2 □ No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. Road

12. Was Decedent Ever in U.S. Armed Forces?

1 | Yes 2 M No If Yes, Give Year or Dates: 700 Beaverbrook death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black ⋧ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than Housekeeper Domestic permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe any injury or other treumatic event, since. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Basil Williams Ouilla Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Curtis / Daughter 20b. Place of Disposition (Name of cametery, crematory or other place)

Ave., Baltimore, Maryland 21216
Date 1-14-05 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/07/2005 Baltimore, Maryland Lorraine Park Ceme. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. Signature of Funeral Service Lic 4611 Park Hgts., Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Xmen 7 Column **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United by that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): been signed by the attending physician a should be detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic preopancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant/opnditions contributing to death but not resulting in the underlying cause given in Part I. \$ Melimonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s 2/ No 1 ☐ Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier /V10

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person

31. Date filed (Month, Day,

Greene Tree Rd

who completed cause of death (Item 23a) (Type, Print)

MASSAN

Ulema 32. Registrar's Signature

			1 - For State Registrar	State of Mary		artment of F			giene 0 0	441	727
			Decedent's Name (First, Middle, Last,)				2. Date of Dea	ath		of Death
	Physic /Medi		Betty Sue Bernh	ard				Decembe	Day er 28. 2	Year 004 9:4	0 P.M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of [4c. County		
			420 Harwood Road			Catons			Balti	more	
	Funeral		Social Security Number 6. Security Number	7. Age (Ir	n yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Birtl	h v. Year)	Birthplace (State Country)	
	Director		216-28-1094	W 245 F	81 Yrs.			Min. (Month, Day Nov. 12	1923	West Virg	inia
	and war		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside	City Limits
	Aaryl feho	ō	Manual 1 D 144								es 21 No
	28e-	Director	Maryland Baltim 10e. Street and Number	iore	Caton	10f. Zip Code			10a Citizan et la		
	within 72 hours after death with the Maryland ane. than "natural", or Items 23e or 28e-f ehow the Medical Eve citiet trust be redified at	ā	420 Harwood Road				220		10g. Citizen of V	•	
	eath	Funeral		12. Was Decedent Ever	rin II S 12 1		228	2 (Specify Vec or No		J.S.A. e - American Indian,	
10	fter d	Fun	1 □ Never Married 2 □ Married	Armed Forces?	13.	f Yes, specify Cuba	an, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	Blac	k, White, etc.	
936	urs a	by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ⊠ No	Specify:		Specify	 White	ے
21215-0036	2 ho	Completed	15. Decedent's Edu		16a. Deced	dent's Usual Occup	ation		16b. Kind of Bu		
215	hin 7 9. an "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most oi d)	f working		,	
21	giene giene	Ю	12	00110g0 (1 401 34)	Hear A	dministr	ator		Federa1	Governme	ent
	e file al Hy l othe vent,	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,			
Maryland	2 should be filed within n and Mental Hygiene. f's marked other than "raumatic event, Ite Mea	To	Hugh Byers				Minr	nie Barker			
ar	2 sho and f fs me		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	g Address (Street	and Number o	or Rural Route Number	r, City or Town,	State, Zip Code)	
	iges 1 and 2 should be filed within 72 hours it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or other traumatic event, Ire Medical Fre		Gary Bernhard (So	n)	12 Hi	lltop Pla	ace Cat	onsville,	Marylan	ıd 21228	
ore.	of He		20a. Method of Disposition		Ob. Place of Dispo					City or Town, State	
Ĕ	Pages nent of I ant: if Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R - 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Lakeview Park		,	2-31-2004	Swkoowi	11 Mary	tland
Baltimore,	2 t t t t		21. Signature of Euneral Service License	9 0/1		. Name and Addres	ss of Facility	ome of Cato	Sykesvi	.ire, Mary	Tand
m	Depar Impo any Ir		(Demand	Talnes	160 16	30 Edmond	eral Ho	ome of Cato re. Catonsv	onsville ville M	, Inc.	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	death. Do not ente	er the mode of dyin	g, such as car	rdiac or respiratory arr	est,	Approxima	ate
	Physician	2	Immediate Cause (Final	42	/	Ca				Interval Be Onset and	d Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	encellar of):	COC.	Cino	2000823		2 m	rnths
	Examiner			Acres	2	omano	2 of his	leution		60	non h
	Control of	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):	UMIDIN	7510	per court	11 24		enny
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	Mys	tother	lenh.	622	leulen		lun	nonto
ó	an ar rial-tı	EX	resulting in death) Last	Due to (or a co	nsequence of):		0				
68760,	icate be executed physician and the burial-transit	dicai									
99	ntifica ng ph as th	Med	15.55.41.5								
Вох	death certifi e attending ed for use as	Physician/Me	230. Was decedent program	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		Ectopic pregnancy			23d. Date	of delivery	
œ.	0 0 0	icia	in the past 12 menths? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at time		Ctopic pregnancy Other (specify)			Mon	th Day	Year
P.0	at the de by the a tached	hys	9 Unknown	9 Unknown							
S, F	law requires that the as been signed by th 2 should be detache	ру Р	Part II. Other significant conditions con	tributing to death but no	ot resulting in the ur	derlying cause give	en in Part I.	23e. Did tot	pacco use contri	bute to the cause of	death?
rd	quire an sig							1 □ Y∈	es 2 □ No :	3 ☐ Probably 4 €	Unknown
Record	aw requis been 2 should	Completed						24a. Was a	n 24b. W	ere autopsy findings	s available
æ	0 4 0	E O						autops perform	ned? de	fore autopsy findings for to completion of ceath?	cause of
	ian: Th rtificate stor, pag	a	25. Was case referred to medical				26 Place of	1 ☐ Yes 2 Death Check on on		☐ Yes 2☐ No	
>	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 Ø No H	ospital:	2 ER/Outpatient	3 □ DOA Othe		ng Home 5 Reside		r (Cassita)	
		n: T	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at	28d. Describe ho	w injury occurre	(Specify)	
ioi	nding I ith. :: After e funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Injury	Work M 1 □ 1	(? Yes 2. □No				
Division	Attanding or death. actor: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, stre	et, factory, office		28f. Location (St	reet and Number	r or Rural Route Nun	mber,
ā	a afte	ert	4 Homicide	building, etc. (S	pecify)			City or Town	i, State)		
	To the Hospitel or Atta within 24 hours after de To the Funeral Diracto completely filled in by th	aic	29a. Certifier 1 Certifying Phys	ician: To the best of my	y knowledge, death	occurred at the tim	e, date and pl	lace, and due to the ca	ause(s) and man	ner as stated.	
	ne Ho n 24 l ne Fu	ledical	(Check only 2 ☐ Medical Examinate)	er: On the basis of example and manner stated.	mination and/or inv	estigation, in my op	oinion, death o	ccurred at the time, da	ate and place, ar	nd due to the cause(s	s)
	within To the comp	M	29b. Signature and title of certifier			29c. License			9d. Date signed	(Month, Day, Year)	
	/			com	4	DY	5274		6120	10 4	
	h		30. Name and address of person who co	npleted cause of death	(Item 23a) (Type, F				61301	07,	
	IJ		Clo Many				204	Catononi	le, n	10 2122	8
	Sta	te	31. Date filed (Month, Day, Year) JAN 0 4 200	3 Registrar's S	Rolling 1						-
	Registr	ar	JAN V 4 200	Elecus	S. Am	المعطا					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiers O.O. I

			1 - For State Registrar	State of Maryla	Cei	rtificate of	Death		iene 0 0	4	41728
	Physici /Medic		1. Decedent's Name (First, Middle, La Jewe11	Eliza	beth	Burke		2. Date of Death Month December	Day	Year 04	3. Time of Death $10:00 AM^{M}$
	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of		
	Funeral		13 Tadcast 5. Social Security Number 6. S		s. last birthday)	If Under 1 Year	Ldorf If Under 24 Hrs.	8. Date of Birth	[rles	ace (State or Foreign
	Director		5,0010201	□M 2\ F 94	Yrs.	Months Days	Hours Min.	(Month, Day, Feb. 14	4,1910	Alal	lace (State or Foreign try) Dama
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo ashingt	on, D.C.				10	0d. Inside City Limits 1 Yes 2 No
	th with the 23s or 28s	Funeral Director	10e. Street and Number 6144 Utah Avenue	NW		10f. Zip Code 2001	5		Og. Citizen of W	hat Count	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Evantinal must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2√√No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		- America k, White, e	
20	72 ho	ted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	eation	10	16b. Kind of Bus	siness/Ind	lustry
2121	ed within giene.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	1	emaker	during most of workind)	ng		Home	3
land	uld be file Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) William Co	mmandor Hinds			18. Mother's Name Se1ma	(First, Middle, M Melvinia			
, Mar	and 2 sho saith and a n 27 is ma		19a. Informant's Name/Relationship (Jewell Estes (Gr	anddaughter)	6144	Utah Ave	and Number or Rura nue NW Was	Route Number, shington	City or Town, S , DC 200	State, Zip 015	Code)
Baltimore, Maryland 21215-0036	Pages 1 nent of He ant: If itan ary or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Indilioval libili State		sition (Name of matory or other place)	000	, , , , , , , , , , , , , , , , , , ,	oc. Location - 0	-	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licer		22	. Name and Addre	ss of Facility Lee ld Alexand	Funera	1 Home,	Inc.	20735
	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the de	ath. Do not ent	er the mode of dyin					Approximate Interval Between Onset and Death 2 years
H	/Medical Examiner		resulting in death)	Due to (or as a conse							
ä	* #£	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	b. Anemia Due to (or as a conse	equence of):					1	lmonth
	acuted nd transit	amin	Cause (Disease or injury that initiated events resulting in death) Last	c. Lower GI B						1	lmonth
68760,	titicate be executed og physician and as the burial-transit	ledicai Examiner	resulting in death, Last	Due to (or as a conse d. Diverticul						5	ōyears
.O. Box 6	The law requires that the death certitics ate has been signed by the attending page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnancy	,		23d. Date Mont		ry Day Year
S, D	uires that I signed by id be deta	by	Part II. Other significant conditions of	ontributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.		_	bute to the	e cause of death?
Record	Physicien: The law requir this certificate has been sl al director, page 2 should	Completed						24a. Was an autopsy perform	pri ad? de		sy findings available
Vital	cian: ertifica ictor,	Be C	25. Was case referred to medical examiner?				26. Place of Death				
of \	Physic this o	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2			4 Nursing Hor				l Living
O	Attanding Physician: or death. actor: Atter this certificator; by the funeral director,	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □No	8d. Describe how	w injury occurred	a	
Division of	al or Attar s after dea I Diractor d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre sify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number State)	r or Rural	Route Number,
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Diractor: Atter th completely tilled in by the funeral	edical C	29a. Certifier (Check only one) 2 Medical Exertifying Ph	ysicien: To the best of my kr niner: On the basis of examir and manner stated.	nowledge, death nation and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the car d at the time, dat	use(s) and mani te and place, an	ner as sta nd due to t	ted. the cause(s)
)	To the within 2 To the complet	W	29b. Signature and title of certifier	Dung	mo	29c. Licens	number	29	d. Date signed	(Month, D	ay, Year)
	h		30. Na e and address of person who		om 23a) (Type,	Print)	#200 T	Inldenf	Marvila	nd 20)604
	Sta	- 4	Stacie D. Gump M 31. Date filed (Month, Day, Year) JAN 0 4 2	.D. 120 32. Registrar's Sign	nature	Line Cen	ter #202 W	aluuil,	LIGI YIGI		

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crn			1 - For Stete Registrar	State of Mi	arylario		tificate of		IIIQ IVIE		Reg. No	007		1 1	29
	°		1. Decedent's Name (First, Middle,	•		·				Date of De	ath		ear	3. Time of	
	Physicia /Medic	an al	Miquel M.				4b Cib. Taura			ecembe	-	8, 200		9:25	Рм
	Examine	er	4a. Facility Name (If not institution, Johns Hopkins				4b. City, Town, or Baltim		rDeath		40	N/			
	Funeral Director				je (In yrs. Ia 30	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. A	Date of Bir (Month, Da pril	th ay, Year)	9 1974	Coun	ace (State o try) 'Ylano	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10	od. Inside Cit	ty Limits
	a-f she	ctor	Maryland N/A	A	Ba	ltimo	ore							₩₩es	2 🗌 No
	death with the Maryland ms 23a or 28a-f show	al Director	10e. Street and Number 1200 Comet MeV	√s			10f. Zip Code 21202	2			10g. Ci	tizen of Wha	at Coun	try?	
36	fter r fta	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates:	?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes X☐ No	lispanic Orig an, Mexican, Specify:	jin? (Specif Puerto Ric	y Yes or No can, etc.)	p-	14. Race - Black, Specify:	White,		
00-	72 hour natural'	ted b	15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation	of working		16b. K	(ind of Busin	ness/Ind	lustry	
21215-0036	d within 7 glene. er than "n	Completed	(Specify only highest Elementary/Secondary (0-12) 8th grade	College (1-4or !	5+)		kind of work done DO NOT use retired ehousema		ar working		Pri	vate	Ind	lustr	У
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Maryland	od 2 shou Ith and M 27 Is mar traumati	-	19a. Informant's Name/Relationshi	p (Type, Print) ny/ Compar	nion	19b. Mailir 1200	ng Address (Street	and Number	ror Rumal F Balt	Route Numb	er, City	or Jown, St.	ate, Zin	Code) - 212	02
ore,	permit. Pages 1 and 3 Department of Health Important: If itam 27 any injury or other tr ance.		20a. Method of Disposition ★□ Burial 2 □ Cremation		20b. Pla	sce of Dispo	esition (Name of matory or other place n Cemet		Date	e 1	20c I	ocation - Ci	ty or To	wn, State Maryl	and
Baltimore,	nit. Pac artment ortant: injury c		* 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Servic	ecity)	WOC										
н 🖀	permit. Departr Imports any inji		Sen He				2. Name and Addre					imor	е,	Md 21	215
			23a. Parti. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	nly one cause on each li	ine.					espiratory a	ırrest,			Approximate Interval Bett Onset and I	ween
	/Medical		disease or condition resulting in death)	a. MULTIP Due to (or as			is hot	WOUNI	25						
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V.	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpati	ient 2X E	R/Outpatier	nt 3 DOA Ott	26. Place ner: 4 ☐ Nui		Check only 5 ☐ Res		6 □Other	(Specify	·)	
n of	ding Phy h. After thii funeral c	ļ-m	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time o	f 28c. Injur	ry at rk?	28		how inju	ury occurred			
Division of Vital Records,	Attending r death. actor: After by the funer	Certification:	2 Accident investig	121.01000	-		P M 1	Yes 2 🔼	28	f. Location	(Street a	nd Number	or Rura	l Route Num	
á	ital or after ral Dira		4 Homicide		nce (Specify,)			27	City or To	THE	ALAMED	A, BY	ALTIMORE	HO
	To tha Hospital or Attent within 24 hours after death To tha Funeral Diractor: completely filled in by the	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the best examiner: On the basis of and manner st	of examinati	vledge, deat on and/or in	h occurred at the tivestigation, in my o	me, date and opinion, deat	d place, and th occurred	d due to the at the time,	cause(s , date an	s) and mann nd place, and	er as st d due to	ated. the cause(s	;)
	To tha within 2 To tha compler	Me	29b. Signature and title of certifier				29c. Licens					ate signed (
			> anet		-dd'- 0'-	00-1 (7		O.C.M.	E.		Dec	ember	20,	2004	
			30. Name and address of person v	who completed cause of	death (Item	23a) (Type, 111	Penn Stre	eet, B	altim	ore, l	Mary	land :	2120)1	
9	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	trar's Signat	ure	park!								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 0 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:50 BURKE HENRY 2004 John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE FRANKLIN SQUARE HOSPITAL CENTER ROSEDALE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Days Hours 1 MM 2□ F Months 218-30-5933 Maryland Director Jun 6, 1936 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Important: If item 27 is marked other then "neturel", or flems 23a or 28a-f ehoven hyjury or other treumatic event, Ithe Medical Examinar must be notified at 1 Yes 2 □ No Director MD Baltimore, N/A Mary and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7804 avenue Wilson 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Bulkle , John Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No à Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WareHouse_ Worker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jean Margaret Elizabeth HanneMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 15 Lork Meadow Court, Baltimore, MD 21236 Momas Burke 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 7,2005 Bacitimas, MD Crematury Metro Joun 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brayson Funeral Home Ringed Nin Ormula Back. MD 21201 trayson W. north 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Priysician /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highry that initiated events resulting in death) Last Due to (or as a consequence of): Examine -transit Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 DIFFICILE COLITIS 1 XYes 2 □ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 💢 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12/27/04 P61251 and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Dr. WASSIM EL-HITTI

JAN 0 4 2005

31. Date filed (Month, Day, Year)

32 Registrar's Signature

9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

		,	For State Registrar	State of Ma	ryland / Depa. <i>Cei</i>	irtment of Healt tificate of Dea	h and Mental Hy eth	/giene 0 0 L	41731
	Dhysiai		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day Year	3. Time of Death
	Physicia /Medic		Valeria Mae Ble				Decem		12:05 a™
	Examin	er	4a. Facility Name (If not institution, give si Lorien Nursing Ho			4b. City, Town, or Locati		4c. County of Death	011
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last birthday)		nder 24 Hrs. 8. Date of Bi		place (State or Foreign
	Director		216-09-9534	м 2√Д F	84 Yrs.	32,0	May 1		yĺand
	yłand now		10a. State 10b. County		10c. City, Town or Lo	cation			IOd. Inside City Limits
	e Mar Be-f st	ctor	Maryland Carrol	l			pstead		1 ☐ Yes 2 ☑ No
	with the or 24	Funeral Director	10e. Street and Number 3800 Normandy Dr.:	ive 2A		10f. Zip Code 210	074	10g. Citizen of What Coul USA	ntry?
	death ms 23	nerai		2. Was Decedent E	ver in U.S. 13.		o Origin? (Specify Yes or Nican, Puerto Rican, etc.)		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23e or 28e-f show any injury or other traumatic avant, I'ls Medical Examinat must be multified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	0	r Yes, specify Cuban, Mex I□Yes 2√2 No <i>Spe</i> d			etc. hite
15-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupation kind of work done during i DO NOT use retired)	most of working	16b. Kind of Business/In	dustry
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	be filed ital Hygi id othar avant, t	Bec	17. Father's Name (First, Middle, Last)				lother's Name (First, Middle	e, Maiden Sumame)	
Maryland	should but a marked umatic s	²	John Rhoten 19a. Informant's Name/Relationship (Typ.	o Crieth	10h Mailie		Emma Martin	ber, City or Town, State, Zip	Cadal
	and 2 sho salth and n 27 is m		Janet Hoffman, d					mpstead, MD 2	
altimore,	Pages 1 and 2 ient of Health int: if itam 27 i		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		sition (Name of natory or other place) I Cemetery	Date 12/31/2004	20c. Location - City or To	
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J	Physician	8 15	Immediate Cause (Final disease or condition	C(pharton	a mul	1/2 formi		Onset and Death
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э, Б	es that tigned by	by Ph	Part II. Other significant conditions conf	ributing to death bu	it not resulting in the u	nderlying cause given in P	2art I. 23e. Did	tobacco use contribute to the	ne cause of death?
ord	w require been sig should b						1 🗆	Yes 2 No 3 Prob	pably 41 Junknown
Vital Records,	The la ate has page 2	Completed					24a. Whas auto perfi 1 🗌 Yes		psy findings available mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		- 9	Place of Death (Check only		
of		n: To	27. Manner of Peath	28a. Date of Injur	y 28b. Time of	t 3 DOA 28c. Injury at Work?	*	how injury occurred	у)
sion	Attending r death. actor: After	atio	1 Natural 5 Pending investigation	(Month, Day	Year) Injury	M 1 Yes 2	2 🗆 No		
Division	= = = =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulg	rry - At home, farm, str . (Specify)	eet, factory, office	28f. Location City or To	(Street and Number or Rura own, State)	d Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funarel Director: completely filled in by the	Medical (29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of ar: On the basis of and manner sta	examination and/or in	occurred at the time, date vestigation, in my opinion,	e and place, and due to the death occurred at the time,	e cause(s) and manner as s , date and place, and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and little of certifier)		29c. License numb	50763	29d. Date signed (Month,	Day, Year)
•	4		30. Name and address of person who con Dr. Ernesto Mendo	COC -	4/7 - 7	Print)	,	,0,00	
	Sta Registr		Dr. Ernesto Mendo	2005 Regis	r's Signature	Sperke			

			4 (9)	epartment of Health and M Certificate of Death	lental Hygie	2004	41732
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Randolph Beverly, Jr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month 12	Day Year 24 4c. County of Death	3. Time of Death 230 PM
	Funeral Director		Future Care Homewood 5. Social Security Number 216-D5.1538 104M 20F 7. Age (In yrs. last birthe	Months Dave Hours Min	8. Date of Birth (Month, Day, Y	PA 17 9. Birthr	place (State or Foreign
	he Maryland 28a-f ehow	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Part	timore			0d. Inside City Limits 1⊠Yes 2 □ No
98	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 le marked other than "natural", or Itama 23a or 28a-f ehow other traumatic event, the Medical Examiter matter melification.	y Funerai Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married	10f. Zip Code 21 217 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White,	ean Indian,
21215-0036	filed within 72 hours Hygiene. Ither than "natural", ent, Ire Medical Ex	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) (6)	ecedent's Usual Occupation Give kind of work done during most of worki DO NOT use retired) CHECKER	ing	b. Kind of Business/In	dustry Baltimore
Maryland	2 should be file and Mental Hy Ie marked othe aumatic event,	To Be C		Liza A		ity or Town, State, Zip	
Baltimore, M	65 0			isposition (Name of crematory or other place)	Date 20	ultimore c. Location - City or To Wilnes Mi	own, State
■ Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funetal Service Licens 2 aug 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	22. Name and Address of Facility Vaugh n. C. Creene F 5/5/ Battmore Natio	uneral Se onal Pile or respiratory arrest	Balto, MD	Approximate
8760,	Any sician /Medical Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Due to (or as a consequence of)	meture Pulmoner	Diser	•	Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be axeculed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ory Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		co use contribute to the	. /
of Vital Records,		Be Completed	25. Was case referred to medical examiner?	26. Plage of Death	24a. Was an autopsy performed 1 Yes 2 2	prior to cor death?	psy findings available inpletion of cause of
Division of V	anding Physiath. or: After this one funaral dir	Certification: To	1 Yes No Hospital: 1 Inpatient 2 ER/Outpater 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not be	ne of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	e 6 Other (Specify njury occurred t and Number or Rura	
Δİ	To the Hospital or Atte within 24 hours after de To the Funaral Direct completely filled in by ti	edical Certif	4 Homicide determined 258. Place of Injury A nome, farm building, etc. (Specify) 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or	leath occurred at the time, date and place, a	City or Town, S	e(s) and manner as st	ated.
	To the P within 24 To the F complete	Med	29b. Signature and title of certifier	29c. License number Dec 5 905 6		Date signed (Month, i	
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty	Resolution RE	Belt M		
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 0 4 2085 32. Registrar's Signature	berte			

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 41733 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year RELL CATHERINE 2004 11.45 P M DEC 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death COUNTY SENERAL HOSPICAL COLUMBIA HOWARD HOW ARD 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 📆 F 217.38.3584 88 Yrs. **Director** DT. 27.1916 Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location irat', or items 23a or 28a-f show Exactiner must be rediffed at 10d. Inside City Limits MD Howard Completed by Funeral Director Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Tumabout 6005 21044 USA Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ⊠Widowed 4 □ Divorced Specify: BLACK "natural" traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. HOME MAKER 6th grade Pages 1 and 2 should be filed ament of Health and Mental Hygic ant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William O. Johnson Hatte Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rosalie B. Anderson/Daughter 6744 Pirch Way Elkridge MD 21075 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō = 5 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 01.06.05 Highland, MD * 4 ☐ Donation 5 ☐ Other (Specify) HOPKINS UM CHURCH 22. Name and Address of Facility
Vanglin C. Greene Funeral Services
SISI Baitimore National Pike Baltimore, MD 21229 21. Signature of Funeral Service Licen 2)augh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CEREBRAL Onset and Death Immediate Cause (Final Priysician INFARCI disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** FIBRILLATION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit or Attending Phyaician: The law requires that the death certificate be executed MISEACE ARTER 7 CONON AR7 Due to (or as a consequence of): Box 68760. HYPERTENSION IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Cther (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEMENTIA 1 Yes 2 No 3 Probably 4 DUnknown Completed PULLION XRY CHRONIC OBSTRUCTIVE DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 32 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To Inpatient 2 ER/Outpatient 3 DOA s after dea... rat Director: After ... by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING D0056948 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8775 CLOVOLEAP COURT, COLVABIA MS 21045 pro TANDINDA 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar JAN 0 4 2005

ORIGINAL

			1- For State of Maryland / Department of Maryl	rtment of Hea tificate of De			2004	41734
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JOAN ANN BARRACATE		Œ	2. Date of Death Month DECEMBE		1
	Examin Funeral	er	HARBOR HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		E MA	B. Date of Birth (Month, Day, y	4c. County of Dea	
	Director		217 40 3456 TIM 222 62 Yrs. Usual Residence of Decedent		Hodis Milli.	Dec. 6,	1942 Ma	ryland
	e Marylar la-f show	ctor	Maryland N/A Baltimor					10d. Inside City Limits 1X Yes 2 ☐ No
	h with th	ai Dire	3712 Brooklyn Avenue	10f. Zip Code 21225	5	100	U.S.	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Exerting Internal technologies and once.	Completed by Funeral Director	1 Never Married 2X Married 1 Tes 2 No	/as Decedent of Hispa Yes, specify Cuban, N ☐ Yes 2√√2 No S	anic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.
21215-0036	within 72 ho lene. than "natui ta Medicul	ompletec	(Specify only highest grade completed) (Give k. life. Di	ent's Usual Occupation ind of work done during O NOT use retired)	on ing most of working	9	8b. Kind of Business Own Home	Industry
Maryland 2	uld be filed Mental Hyg srked other	To Be C	17. Father's Name (First, Middle, Last) William Cavey	18.	B. Mother's Name (Edna	(First, Middle, Ma	uiden Sumame)	
	nd 2 sho alth and 1 27 is me r traume			Address (Street and Redthorn			City or Town, State,	
Baltimore,	Pages 1 and neut of Hesaurt; If itam			ition (Name of atory or other place) rk Cemeter	Da	ite 20	oc. Location - City or altimore,	Town, State
Balt	permit. Departr Imports any inj		Janua M srameroushi 40	Name and Address of Ritchie	e Highway	/ Balt	imore, Ma	ce, P.A. ryland 21225
4	Physician		234. Part 1. Enter the disease of emplications that caused the death. Do not enter shock, or heart failure. (ist only one cause on each line. Immediate Cause (Final disease or condition		such as cardiac or		t,	Approximate Interval Between Onset and Death Months
	/Medical Examiner		Due to (or as a consequence of):	LONG	CAINCE			15 DAYS
8760, 🤝	Attanding Physician: The law requires that the death certificate be executed in death. sector: After this certificate has been signed by the attending physician and better this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c					
c 687	ortificate ing physi s as the b	Medica	IF FEMALE:					
P.O. Box	that the death certifica ed by the attending ph detached for use as th	lysician/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in	in Part I.	23e. Did tobac		o the cause of death?
Division of Vital Records,	ician: The law r certificate has be rector, page 2 sh	Completed					prior to	utopsy findings available completion of cause of
f Vit	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Tempatient 2 ER/Outpatient	0.1	 Place of Death (4 ☐ Nursing Home 		ce 6 □Other (Spe	ocify)
sion o	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification;	27. Manner of Death Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		s 2 🗆 No	3d. Describe how	injury occurred et and Number or R	um I Pouto Alumba
Ω	i Dite		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	et, factory, office	20	City or Town,	State)	urai noute Number,
	To tha Hospital within 24 hours of To the Funaral I completely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the best of the best of the best of the best of the best of the best of the best of the best of the best of my knowledge, death of the best of the	occurred at the time, of astigation, in my opinion	date and place, an ion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License nu			Date signed (Mont	th, Day, Year)
	10			HANOVER S	ST BALTI			5
	Sta Registr		31. Date filed (Month, JAN 0 4 2005 32. Faistrar's Signature	in the				

		•	1- State of Marylan		artment of H			0 0 Sens	14	41735
	Physici		1. Decedent's Name (First, Middle, Last) John J. Bryl				2. Date of Death Month December	29 20)°04	3. Time of Death 5:00 P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Serenity Inc. Assisted Living	3	4b. City, Town, or Linth	Location of Death		4c. County o		ınde1
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 11		Coun	olace (State or Foreign otry) 11and
	f show	or		y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2√ No
	vith the h or 28e-	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of W	hat Coun	itry?
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-5 show any righty or other treumette event, I're Madical Exacilinat: ust be notified at once.	Funeral	36 Governors Gate Lane 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U Armed Forces? 1 □ Tyres 2 □ No 11 ∀es, Give WWT		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	Americ , White, Whi	
21215-0036	in 72 hours "neturel",	Completed by	15. Decedent's Education (Specify only highest grade completed)	1		ation during most of work	ring 1	Sb. Kind of Bu		
d 212	filed with Hygiene. ther ther of, the M		Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)		iceman.		e (First, Middle, Ma	Baltin		City
Maryland	ould be Mental Marked o	To Be	Stanley Shalcoski			Mar	y Barbar	a Bry1		
, Mar	and 2 sh alth and 27 is n er treum		19a. Informant's Name/Relationship (Type, Print) Anna Mary Pilko / sister	4	•		al Route Number, venue Be			nois 60402
altimore,	ages 1 and of He t; If item y or oth		1 🔀 Burial 2 Cremation 3 Removal from State	emetery, cren	sition (Name of natory or other places SS Cemete	e)		Oc. Location - (•	
Baltir	permit. P Departme Importen any injura		21. Signature of Funeral Service Licensee	22	. Name and Addres		once Fune	ral Sei	vice	Maryland e, P.A. yland 21225
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease or complications that caused the deet shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a	n. Do not enter		g, such as cardiac				Approximate Interval Between Onset and Death
68760,~\	tificate be executed g physician and as the burial-transit	ledical Examiner	ause. Enter Underlying Cause (breas a consequence of the cause of the cause) to for as a consequence of the cause of the c	5	-	- shifts for				
.O. Box	The law requires that the death certifi ate has been signed by the attending l page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnat 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ory Day Year
<u>α</u>	v requires that t been signed by should be detac	by	Part II. Other significant conditions contributing to death but not res Diabetes mellitus	ulting in the ur	nderlying cause givi	en in Part I.			bute to th	ne cause of death?
Vital Records,		Completed	Peripheral vascular disease	2			24a. Was an autopsy performe 1 Yes 2	pr pd? de	ior to cor	psy findings available upletion of cause of
Division of Vit	ding Phys h. After this funeral dii	ation: To Be	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	ER/Outpatien 28b. Time of Injury	28c. Injun World	er: 4 Nursing Ho	th (Check only one) ome 5 ☐ Residen 28d. Describe how	1		Assisted lung
Divis	P # 15 E	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		r or Rura	Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dit completely filled in	edical C	29a. Centifer (Check only one) 1 Centifying Physician: To the basis of examina and manner stated.	wiedge, deati	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and man e and place, a	ner as si nd due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of extifier	10	29c. License	number	290	d. Date signed	(Month, I	Day, Year)
,			30. Name and address of person who completed cause of death (Item	n 23a) (Type,	Print)	161189		14/	30/	04
	GT	•	606 Hammonds lane, Stel	-2 (3 roblyn	Park, MD	21775			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 2005	V K	good					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 26 per phys 839 1-4-05 yt State of Maryland Bepartment of Health and Mental Hygiepe () [For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Ella Margaret Burket 19, 9:35 P 2004 December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll 7251 Vicky Drive Woodbine If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1 □ M 2 🔀 F 88 March 22, 1916 Pennsylvania 214-38-5532 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Woodbine Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 United States 7251 Vicky Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No White Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emma Mary Mann William Harvey Weyant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7251 Vicky Drive, Woodbine, Maryland 21797 Loretta Bush - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/23/2004 Brooklyn Park, Maryland Cedar Hill Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatur of Funeral Service Lit 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

1 Yes 2 No

H00585 98

210 BUSINESS

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

STETISTOWN, MI)

Pnysician /Medical Examiner

Department of Important: If it any injury or o

Physician

/Medical

Examiner

10a. State

Funeral

Director

items 23a or 28a-f show

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"neturel"

al Hygiene.

is marked o

item 27

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Director

Completed by Funeral

Be

other traumatic event, the Medical Examiner must be notified at

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

use as the burial-transit Physician/Medical detached 20 page 2 should be Be Completed

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records.

P.O. Box 68760.

Examine Medical Certification: To 27. Manner of Death

1 ☐ Yes 2 ☐ No

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAROOR

6 Could not be determined

1 Matural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year).

3 Suicide

29a. Certifier

shock, or heart failure. List or	nly one cause on each line.	or respiratory arrest,	in	nterval Between
Immediate Cause (Final disease or condition	CVA		0	inset and Death
resulting in death)	Due to (or as a consequence of):			
	5EP515			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
that initiated events resulting in death) Last	C. Due to (or as a consequence of):			
IF FEMALE:	23c. If yes, outcome of pregnancy		204 Data of dalling	
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Da	
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.		se contribute to the	_
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy prior to comp death?	
25. Was case referred to medical	26. Place of Dea	th (Check only one)		

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

within 24 hours after death.

filled in by

completely

6

State Registrar

			1 - For State Registrar	State of Maryland /	Depa			Mental Hy	Reg. No.	41737
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Mavadell Barker 4a. Facility Name (If not institution, give s GENESIS ELDER CA	street and number)	lor	BALTI			Day Year POR 27, 200 4c. County of De	04 10:30 AM
	Funeral Director		5. Social Security Number 6. Sex 236–18–1825	7. Age (In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Yeer) 9. B y, 1918 Wes	irthplace (State or Foreign Country) st Virginia
	death with the Maryland me 23a or 28a-f show	Director	10a. State 10b. County Maryland Baltimor	e 10c. City, To	own or Loc Balti	more				10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 2	i Dir	10e. Street and Number 3310 Benson Avenue	<u>!</u>		10f. Zip Code	21227		10g. Citizen of What C United S	
9	be filed within 72 hours after death with the Marylan tall Hygione. Ad other then "naturelt, or iteme 23a or 28a-f show event, the Marusal Examinas in this be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		/as Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify: W	
0000-0171	within /2 hours after ene. then "naturel", or its in wedges Extention	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 completed) College (1-4or 5+)	(Give k	ent's Usual Occup and of work done O NOT use retired irdress	during most of wo	rking	16b. Kind of Busines	s/Industry
א ס	ild be filed v lental Hygie ked other t ilc event, th	To Be Co	17. Father's Name (First, Middle, Last) Archie C. Nicho	olson			18. Mother's Nar	me (First, Middle, a Carrice	Maiden Sumame)	
AIG.	and 2 should and Market and Market Ma	-	19a. Informant's Name/Relationship (Ty, Rev. James M. Bark						or, City or Town, State, Forest Hil	Zip Code) 1, MD 21050
parimore,	permit. Pages 1 and 2 should Department of Heatth and Mer Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ R 4. □ Don tion 5 □ Other (Specify)	Crest	Law	ntion (Name of atory or other place n Gardens	s 12/30		20c. Location - City of Marriottsv	ille, MD
Dai	Depart Depart Import any in		21. Bonatur of Funeral Service License	and I					uneral Home imore, Mary	e, Inc. yland 21229
/on, in	ale pe executed //Medical instruction and provide-transit the burial-transit	Ilcal Examiner	23a. Part1. Eater the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list condition fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	PUL te of):	-MONA	Ry AR	RES)	Jay Vaknoi	Approximate Interval Between Onset and Death IAJATO 4 W10.357W W - FEW MONTHS
O. DOX 00	w requires that the death certifical been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
necolds, r.	Ine law requires that the deam, ate has been signed by the atten page 2 should be detached for u	by	PATIENT WAS				en in Part I.	1 🗆 Y		Probably 4 Unknown
	ine la ate has page 2	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was a autop perfor 1 Yes	sy prior to med? death? 2 No 1 Ye	autopsy findings available completion of cause of s 2 No
5 7	rnysician: r this certific ral director,	To B	1 105 22 140	ospital: 1 Inpatient 2 ER/0	Outpatient	3□ DOA Oth			ence 6 Other (Sp.	ecify)
DISION		Certification:	27. Magner of Death 1 Anatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Yeer)	. Time of Injury		yat k? Yes 2 □ No		ow injury occurred	2 1 2 11 1
	lo tre hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Tow		
	ne Hos n 24 hc he Fun pietely	edical	(Check only 2 Medical Examir	ner: On the basis of examination a and manner stated.	and/or inve	estigation, in my o	pinion, death occu	irred at the time, o	date and place, and du	e to the cause(s)
1	To the comp	M	29b. Signature and title of certifier				o 608		29d. Date signed (Mon	nth, Day, Year)
	(O) Sta	ate_	30. Name and address of person who co		(N)	LICENC	AVEN	VE, BAL	TIMORE, N	10-21229
1	Registr	rar	1811 0 X 20	05	. 4	and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie on 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Butterworth, Jr. 2004 5:30AM M Ν. Lrnest December 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months Aug. 19, 1954 1 € M 2 □ F 216-66-8860 50 West Virginia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maxical Examiner must be rigitled at 1 ☐ Yes 2 ☐ No Director MD N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2820 Louise Avenue U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 11 Truck Driver Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest N. Butterworth, Sr. Louise White Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pamela Butterworth-Wife 2820 Louise Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hilltop Service Corp. 1/3/05 Towson, Maryland 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 2 No 1 Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2. ■ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: al or Attending P after death. I Director: After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗋 Homicide To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 020396 31,2004

Registrar

State

Loch

Registrar's Signature

Waven

Blad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Hahn

2005

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** xecember 29,2004 sow man /Medical 4a. Facility Name (If not institution, give street and number 4h. City. Town, or Location of Death 4c. County of Death Examiner Social Security Number 6. Sex rs. last birthday Birthplace **Funeral** 1 ☐ M 2 X F 219-78-54/8 Usual Residence of Decedent Days Min. Director Pages 1 and 2 should ba filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Maryland mor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during 16b. Kind of Business/Industry (Specify only highest grade completed) kind of work done during most of working DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) O 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) l and Mantal I 19a. Informant's Name/Relationship (Type, Print) (Cousin) 19b. Mailing Address (Street and Number r Rural Route Number, City or Town, State, Zip Code) Son 3332 20b. Place of Disposition (Name of Monda Department of Health a Important: If item 27 is any injury or other tra 20a. Method of Disposition 20c. Location 1 ☐ Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 Other (Specify) 22. Name and Address of Fal ility Ave. Not Approximate Interval Between Onset and Death if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck, or heart fail Physician diseale disease or condition resulting in death) Carcijovascalar sclevato 1 /Medical Due to (or as a consequence of): Examiner abeses Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit or hi Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medicai monar IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2[] No 1 Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3X DOA Certification: To 1 Yes 2 No 2 ER/Outpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1-Natural 5 Pending 1 Yes 2 No investigation 2 Accident within 24 hours after deatl To tha Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tunhul Gong mi) Bal NEw Tunhui NEWTON Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2005 Registrar

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year ALVIN BECKER 11:15 AM 28 2004 December /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore N/A Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) MAR. 2, 1921 Birthplace (State or Foreign Country) **Funeral** 6. Sex 1 M 2□ F Months Days Hours Yrs. 83 Director 218-05-5742 MD Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itams 23a or 28a-f shov the Modical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No RANDALLSTOWN BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8802 MEADOW HEIGHTS ROAD 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XiYes 2 □ No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Be Completed by If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. SUPERI NTENDENT ALLIED CHEMICAL itam 27 Is marked other other traumatic avant, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental **BECKER** HYMAN YETTA APPLESTEIN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of itam 27 l MARCI ROSENBAUM / DAUGHTER 3508 OLD COURT ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State MIKRO KODESH BETH ISRAEL 1/2/05 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 24 hours /Medical Due to (or as a consequence of): **Examiner** Chronic respiratory failure 30 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 200 2 No 1 Yes 1 Yes ours after death.

naral Diractor: After this certifica
filled in by the funeral director, i Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 December 28, 2004 Duanne lun, Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospitai el Baitimore Julianne Kenton, MD 31. Date filed (Month, Day, Year) State Boun Is Boo Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere [] [] 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2004 ٧. Bisesi December <u>11:</u>05 P[™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 0.06 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 214-24-9358 75 Yrs. Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or? 7732 West Drive 21060 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No ith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam Specify: 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Household 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James R. Sands 01ive Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 J 7732 West Drive, Glen Burnie, MD 21060 Frank Bisesi (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition n. 04 2005 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. Jan. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility 2. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dicease, or con shock, or heart failure. List only ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Emplysem Immediate Cause (Final Physician disease or condition resulting in death) YELLTI /Medical Due to (or as a consequence of): Examiner Alzheimer's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a dor sequence of) Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the sahould be detached Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 105 Name and address of person who completed cause of death (Item 23a) (Type, Print) 140 MARISON COSK Colon Busnie 21061. 10 Niscioce 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

04.	+1		1- State Inpend Item 23:	State of Maryland				•		e. . l. 171.9
			1 - State Tipe III I Lem 236 Registrar	a,pt.11,27,200	- Cei	tificate of Dea	ath		. No. U U L	4 41142
	Physici	an	1. Decedent's Name (First, Middle, Last)	g nya nya nya				Date of Death Month	Day Y	3. Time of Death
	/Medic		Albert Lylle Bel					December	29, 200	
}	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or Loca			4c. County of	
			4041 Gill Avenue, A		act hirthday)	Hampstead	Inder 24 Hrs.	9 Date of Birth		ll County
	Funeral Director		215-64-1679 12	M 2□F 50	Yrs.		ours Min.	8. Date of Birth (Month, Day, Y July 14,	(ear) 1954 E	Birthplace (State or Foreign Country) ennsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ō	Maryland Carroll	Ha	mpstea	ıd				1 ∑Yes 2 No
	28a	Director	10e. Street and Number			10f. Zip Code		100	J. Citizen of Wha	at Country?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "natural", or Items 23a on 23a-f na Majical Examiner must be notified at		4041 Gill Ave. A	pt. 204		21074			U.S.A.	
	death ms 2	by Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13. \	Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Spe	cify Yes or No-		American Indian,
9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	i	_ 37	exican, Puerto i <i>ecify:</i>	Hican, etc.)		White, etc.
ဗ္ဗ	ours iral',	d b	3 ☐ Widowed 4 ₺ Divorced	Year or Dates:		10 165 220 NO Sp	өспу.		Specify:	White
Maryland 21215-0036	72 h "natu	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced (Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of worki	ng 16	b. Kind of Busin	ess/Industry
7	within ne. han	m m	Elementary/Secondary (0-12)	College (1-4or 5+)		ruck Driver		i	Dand Com	
5	filed v Hygle other t		17. Father's Name (First, Middle, Last)				Mother's Name	(First, Middle, Ma		struction
and	otal l	Be c	Albert Lylle Belt,	Jr.			lav Naor	,	.com comamo,	
Ē	2 should be f and Mental P is marked of sumatic ave	은	19a. Informant's Name/Relationship (Ty)		19b Mailin	g Address (Street and N	0		City or Town Sta	ate Zin Code)
<u>≅</u>	d 2 s th an t7 is trau		Bonnie Belt - siste			S. Main St.			-	no, zip oodo)
ō,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Menth Hylaene. Important: If tam 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic avent. It a Madical Examiner man be notified at once.		20a. Method of Disposition	20b. P!	Language Company	sition (Name of natory or other place)				y or Town, State
Baltimore,	Pages nent of int: If It iny or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)			natory or other place) Mem. Garde	ens Jan.	4.2005	Finksh	ure. Md.
₫	artme ortar injur		21. Signature of Funeral Service License							
B	Depa Impo any ii		J. Hate Eller	io e	32	Name and Address of khardt fune 96 Charmil	eral Cha Dr. Man	apel P.A. Ichester	Md - 21	102
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death						Approximate Interval Between
b	Pnysician ·		Immediate Cause (Final		do To	torioation				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ		LOXICALION				
В	Examiner		O							
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as a consequ	ence of):					
	le be executed ysician and e burial-transit	Examiner	that initiated events	•						
760,	e exe ian a urial-		resulting in death) Last	Due to (or as a consequ	ence of):					
		lical								
89 ×	entific ding F	Physician/Med	IF FEMALE:	Co. If you subsemp of program						
Bo	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar	death 3	Ectopic pregnancy			23d. Date o Month	f delivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	atn 5∟	Other (specify)				
۳.	that the ded by detac	'Ph	Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	nderlying cause given in	Part I.	23e. Did toba	cco use contribu	ite to the cause of death?
ds,	w requires that been signed b should be det	Completed by	Hypertensive Ather					1 ☐ Yes	2 □ No 3[Probably 4 Unknown
COL	w req beer shou	lete						24a. Was an	24h Wer	re autopsy findings available
Re	he la has ige 2	mo						autopsy performe	d? prio	r to completion of cause of the?
a	n: T flicate or, pa	e Co	25. Was case referred to medical			26	Disease Death	1 Yes 2	No 1/2	Yes 2□ No
5	s cert directe	o B	examiner?	ospital: 1 Inpatient 2 1	ER/Outpatien	0.1		(Check only one)	o 6 TOther	Specify) At scene
Division of Vital Records, P.O. Box	a Phy er this	L.	27. Manner of Death	28a Date of Injuny	28b. Time of	28c. Injury at		28d. Describe how		Specify At Scelle
o	nding ath. r: Afte e fun	atlo	1 Natural 5 Pending 2X Accident Investigation	Found, Day Year)	8 und ,	Work? 1 ☐ Yes		Subject (monoxide	exposed	to carbon
<u>Vi</u> S	Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str			28f. Location /Stre	et and Number of	or Rural Route Number,
Ö	tal or rs afte al Di	Certification: T		Residence			H	ampstead	, MD 41	Gill Ave.#204
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending ph To the Funaral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only 2X Medical Examin	sician: To the best of my knowner: On the basis of examinat	vledge, death ion and/or inv	n occurred at the time, da vestigation, in my opinion	ate and place, a n, death occurre	and due to the cau ed at the time, date	se(s) and manne and place, and	er as stated. due to the cause(s)
	o the ithin 2 o the	Mec	one) 29b. Signature and title of certifier	and manner stated.		29c. License nun	nber	29d	. Date signed /A	fonth, Day, Year)
	F ≱ F 8		DA WAR IL	\$ 000 11 101	1	OCME				30, 2004
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Tune	Print)				
			CAROL H ALLAN	ind	_ou/ (19pe,	111 Penr	Street	t, Baltin	nore, Ma	ryland 21201
	Sta	ite	31. Date filed (Month, Day, Year)	22. Registrar's Signat	ure					
	Registr		IAN 0 4 2005	Parker &	Sugar	Les .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen [] For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 31, **Physician** 2004 MARY LUCY CLASSON 10:40 A.M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Director AUG.IS JARM 812-01-0959 Usuel Residence of Decedent death with the Maryland 10a. State 10c. City. Town or Location 10b County 10d. Inside City Limits ir than "natural", or itams 23a or 28a-f show The Medical Examiner must be notified at 1 ☐Yes 2 No Directo MARYLAND BILATR HARFORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? V.S.A 1304 H. Funeral 21012 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ould be filed within 72 hours after or Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 15€ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 13765. HUTZLER BROTHERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DOWARD JOSSPH ELASSON JR. IARY LURH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if item 27 is n any injury or othar traum BUFIR HARRY B-LLASSON ()AN AND RIVE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State F. MAL 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BALLIFERERZ LAJ 202KTP 2005 21. Signature of Funeral Service License 22. Name and Address of Facility EHAREL-BELRIR, P.A. 3 TEWPORT DRIVE FOI 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** demiles /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**X** No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar DR. DAVID DUNN

31. Date filed (Month ANY, Year) 2005

615 W. MacPHAIL ROAD

32 Registrar's Signature

Selve.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

33222

BEL AIR, MD.

21014

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H rtificate of	lealth and Death		gie pe () () ()	41744
	Physici /Medic		1. Decedent's Name (First, Middle, La Carolyn A.	Creager				2. Date of De Month 12/	ath Day 2004	3. Time of Death 9:45pm M
	Examir		4a. Facility Name (If not institution, given Harbor Hospita)		ore Cit	У		eath I/A
E	Funeral Director		212-20-8113	Sex 7. A 1 □ M 2120 F	ge (In yrs. last birthday) 80 yrs.	If Under 1 Year Months Days	If Under 24 I Hours M	Hrs. 8. Date of Bin (Month, Da 5/ 19/	th y, Year) 9. E 1924	Birthplace (State or Foreign Country) MD
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County N/A		10c. City, Town or Lo	Baltime	ore			10d. Inside City Limits 12⊞Ves 2□No
	h with the	Funeral Director	10e. Street and Number 1423 Covington S	treet		10f. Zip Code	21230		10g. Citizen of What US	'
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other then "natural", or items 23e or 28e-f show or other treumatic event, the Medical Exartinar rutal be Indiffied at	ğ	11. Marital Status 1 Never Married 2 Married 3CXVidowed 4 Divorced	12. Was Deceden Amed Forces 1 Yes 2 If Yes, Give Year or Dates:	? No	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2001	dispanic Origin? an, Mexican, Pe Specify:	(Specify Yes or No uerto Rican, etc.)	14. Race - Al Black, W Specify:	merican Indian, hite, etc. White
21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind of Busine	ss/Industry m Home
	12 should be filed within 'n and Mental Hygiene. 7 le marked other then "Ireumatic event, the Med	To Be Co	17. Father's Name (First, Middle, Las Louis A. Schwan				18. Mother's	Name (First, Middle, Mary E.Ø	Maiden Sumame)	
Maryland	alth and Malth a		19a. Informant's Name/Relationship Peter Creager,						ar, City or Town, State idge Maryl	
Baltimore,	permit. Pages 1 and 2. Department of Health ar Important: If item 27 le any injury or other treu		20a. Method of Disposition 1 X Burial 2 Cremation 3 [4 Donation 5 Other (Special Content of the content of t	fy)	Holy Cro	matory or other pla SS Cem.	01	Date /3/2005		or Town, State Maryland
Balt	permit. Departr Importa any inju		21. Signature of Funeral Savia Lice	nsee Victor F	2. Doda, Jr. 2 1	2. Name and Address L. S 001 East Fo	ess of Facility Stevens Fl ort Avenue	uneral Home, e, Baltimore	Inc. MD 21230	
	Fnysician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.		t			Approximate Interval Between Onset and Death
	Examiner	ا ا	Sequentially list conditions,	0.	s a consequence of): THE OWN	rutin	Lung	Diseac	/	10 years
8760,	icate be executed physician and s the burial-transit	dicai Examiner	any, leading to annicular cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o	delivery Day Year
Ω_	quires that t n signed by uld be deta	ed by Ph	Part II. Other significant conditions Seinen fix	contributing to death	but not resulting in the u	nderlying cause gr	ven in Part I.			to the cause of death?
I Records,	The law requir ate has been si page 2 should	Completed by			-				rmed? prior t	autopsy findings available o completion of cause of ?
f Vital	Physicien: this certific	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	tient 2 EP/Outpatie	nt 3□ DOA Cth	oor	Death (Check only o	one) dence 6 □Other (S	pecify)
sion of	ling After fune	ation:	27. Manner of Death 1 Actural 5 Pending 2 Accident investigate		jury 28b. Time o ay Year) Injury	Wo	ry at rk? Yes 2 ☐ No	28d. Describe	now injury occurred	
Division	tel or Att	Certification:	3 Suicide 6 Could not determined	28e. Place of It	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the i	Medical	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manner s	t of my knowledge, deat of examination and/or in stated.	vestigation, in my	opinion, death o	ccurred at the time,	date and place, and d	ue to the cause(s)
)	or with	2	29b. Signature and like of certifier	len	n'n	29c. Licens	3055	-5	29d. Date signed (Mo	nth, Day, Year)
	b		Alan N. Do	innes	death (Item 23a) (Type, 901 E, 7	o-1 Au	e. Da	Hunver	, MD 2	1230
1	Sta Regist		31. Date filed (Month, Day Year)	4 2005 32. Reg	rar's Signature	Sporte				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	State Registrar 1. Decedent's Nar	me (First, Middle, La			Certificate of		2. Date of De		3. Time of Death
cian lical	Chad	Daniel O	amnings				Decembe	er 23, 2004	0514 a ^M
iner		(If not institution, giver rsity Hos	re street and number) pital		4b. City, Town, o Baltimor	r Location of Deat C	h	4c. County of Dea	ith
it r	5. Social Security 214–02–32	19	Sex 7. Age	(In yrs. last birthd	Months Davs	If Under 24 Hrs Hours Min.	(Month, Da	9. Bir y, Year) 9. Bir 29, 1982	thplace (State or Foreigr ountry) Maryland
tor	Usual Residence 10a. State Maryland	10b. County N/A		10c. City, Town o		e City, M	D		10d. Inside City Limits
Director	10e. Street and N 1112 River	_{umber} rside Avenue)		10f. Zip Code	1230		10g. Citizen of What Co	ountry? ed States
by Funeral		rried 2 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 2 1 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ YNO			- 14. Race - Ame Black, Whit	erican Indian,
Completed	(Spe	15. Decedent's E ecify only highest gr		(6	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired	during most of wo	rking	16b. Kind of Business	/Industry
omo	Elementary/Sec 10	condary (0-12)	College (1-4or 5-	+) ""	Laborer			General	
To Be C		Ray Cumming					me (First, Middle, Holtz	Maiden Surname)	
		Name/Relationship (z / Mother	Type, Print)		-			er, City or Town, State, Maryland 21:	
1	20a. Method of D		Removal from State	20b. Place of Di cemetery,	isposition (Name of crematory or other place	ce)	Date	20c. Location - City or	Town, State
	` 4 Donation	5 Other (Speci	fy)		Fill Cemetery 22. Name and Addre		er 28, 200	4 Glen Burnie	e, Maryland
	21. Signature of	The same of	Victor P.	Doda, Jr.	Charles L. S 1501 Fast Fo	Stevens Fur	neral Home	, Inc.	
er le	disease or condit resulting in death			Intoxical consequence of):	ation and (Cocaine l	Jse		
cal Examiner	Sequentially list of any, leading to cause. Enter Und Cause (Disease that initiated ever resulting in death	derlying or injury ots	c	a consequence of):	:				
a	Cause, Enter Und Cause (Disease of that initiated even	derlying or injury its) Last ent pregnant 2 months?	Due to (or as a	a consequence of): of pregnancy 2	:	,		23d. Date of de Month	livery Day Year
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DHMH 17 Rev 1/2001

		ľ	For State Registrar	State o	f Marylar		artment of F		and Mental H	ygiene		41746
	٥		1. Decedent's Name (First, Middle	e, Last)					2. Date of I	Death	/ Year	3. Time of Death
	Physicia /Medic		Maphry L. Ca	irens					Decen	ber 3	30, 2004	11:55 a ^M
	Examin	er	4a. Facility Name (If not institution		mber)		4b. City, Town, or	r Location of	of Death		County of Death	
			Riverview Care		7 4 //	14 bi-sb (3	Essex If Under 1 Year	If Under	24 Hrs. 0 D 4 F		Baltimore	
П	Funeral Director		5. Social Security Number 464-01-5947	6. Sex 1 ☐ M 2 2O \$F	7. Age (In yrs. 91	Yrs.	Months Days	Hours		Day, Year)	9. Birth	olace (State or Foreign
			Usual Residence of Decedent		91				rep. 2	1,191	3 Nort	th Carolina
	ylanc		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
	e Ma la-1 s	cto	Maryland Balti	more	E	ssex						1 ☐ Yes 2√2√No
	or 28	Dire	100. Street and Number	ronue And	- E10		10f. Zip Code 21221				izen of What Cour	ntry?
	s 23e	Funeral Director	1000 Franklin A			10 10		lianania Osi	ning (Specific Vector)	1	S.A.	oon Indian
	ter de Itam inerr	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo			If Yes, specify Cuba	an, Mexicar	gin? (Specify Yes or I n, Puerto Rican, etc.)	NO-	Black, White,	
920	ursat mal', or	by	₩₩idowed 4 Divorced	If Yes, Gi	ve		1 ☐ Yes 2 ☒ No	Specify:			Specify: Whi	ite
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Ind other than "natural", or Itams 23a or 28a-f show avant. The Medical Evanitrer must be rediffed at	Completed		it's Education st grade completed)			dent's Usual Occup		t of working	16b. Ki	ind of Business/In	dustry
2	ithin e. . mer	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)				
2	e filed within al Hygiene. I other than ' vant, the Me		1 2 17. Father's Name (First, Middle,	/ aet)		Sales	Associa		er's Name (First, Midd	Sho		
anc	ntal hed of	Ве	William F. Gard							io, ivialuoti	Sumamej	
Maryland	ges 1 and 2 should be nt of Health and Mental : If itam 27 is marked o or othar traumatic ave	70	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street		e Wilson er or Rural Route Nurr	nber, City or	r Town, State, Zip	Code)
	nd 2 :		Billy Cairens (Son)		8819	Trimble	Way,	Baltimore,	Mary	land 212	237
ře,	of Heal itam 2 othar		20a. Method of Disposition	- 77	20b. f		osition (Name of matory or other place		Date		ocation - City or To	
Ē	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (S		State	sgah G			Jan.4,2005	Bre	vard, N.	C.
Baltimore,	permit. Pages Department of H Important: If its any injury or of		21. Signature of Funeral Service	Licensee		22	Name and Address Br	ss of Facilit UZQZ1 Fact	nski Funer	al Ho	me, P.A.	land 21221
10		-4	23a. Part1. Enter the disease, or shock or heart failure. List			th. Do not ent					ex, mary	Approximate Interval Between
	Pnysician :		Immediate Cause (Final diseas or condition	1 11	B	o Mahi	c (Nen	nery	Arken	Di	ilere	Onset and Death
	/Medical		resulting in death)	a. Liv	(or as a consec				,,,,,,	4-7		CCC T
	Examiner		Sequentially list conditions,	b								
	pe sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	juence of j.						
	xecut and II-tran	Examin	that initiated events resulting in death) Last	c	(or as a consec	quence of):						
8760,	cate be executed physician and s the burial-transit	icalE		d								
9	iiticate g phy as the	ed		u								
Вох	law requires that the death certilica as been signed by the attending ph 2 should be detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		Ectopic pregnancy	,		2	23d. Date of delive	,
	ne deal the att hed to	sicis	in the past 12 months? 1 □ Yes 2 ☑ No		ant at time of o		Other (specify)				Month	Day Year
P.O.	that the de ed by the detached	Phy	9 Unknown Part II. Dther significant conditi			ultima in the	- d	an in Dad I	320 Die	1 tobooo	an contain to to the	he cause of death?
	signed of the det	by	Adrian Co	d Da	mont	taling in the d	DUT	en in Fait i				pably 4 Unknown
Ö	w requir	Completed	IDPD				V I					
Rec	و ح ق	mp		•					24a. Wa	topsy formed?	prior to co	psy findings available mpletion of cause of
la	ician: Th	e Co	25. Was case referred to medica	1				OF Blood	1 Yes		1 🗆 Yes	2EN0
5		OB	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth		of Death (Check only ursing Home 5 Re		6 Other (Specific	iv)
1 0	g Physer this leral di	-	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time or			28d. Describ			,
ion	ath. rr: Att	atlo	1 Naturał 5 ☐ Pendir 2 ☐ Accident investi	gation	in, Day 19ai)	injury		Yes 2	No			
Division of Vital Records,	rr Atta ter de iracto iracto	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace	of Injury - At hing, etc. (Speci	ome, farm, str	eet, factory, office			(Street and own, State)	d Number or Rura)	I Route Number,
	urs att											
	To tha Hospital or Attanding Phywithin 24 hours after death. To tha Funeral Diractor: Atter thi completely filled in by the funeral.	dical		Examiner: On the b					id place, and due to the th occurred at the time			
	ro tha vithin ro tha	Me	29b. Signature and title of certifie	ər			29c. Licens	e number		29d. Date	e signed (Month,	Day, Year)
	A		► Alson	MD.			D-	-38	154	12	30-	2004
	19		30. Name and address of person	who completed cau.	se of death (Iter	n 23a) (Type,	Print) ASTER	N	754 BLVD_	M	-D-21	221
	Sta Registr		31. Date filed (Month, Day, Year, JAN 0		legistrar's Signa							
		÷.	9,11,0		ANTERIA Y	15						

			State of Maryland / Dep		•	_	
			, rot	ertificate of Death		2004	61767
ľ			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Edith DeYoung Conley		December		9:45A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	h
_			Charlestown Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Catonsville VI If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimo	
Н	Funeral Director		215–48–5415 1 M 2 S F 91 Yrs.	Months Days Hours Min.	Feb. 9,19	(ear) Co	hplace (State or Foreign untry) Lucky
	D		Usual Residence of Decedent		red. Jii	713 Kent	Lucky
	arylar ahow	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	Maryland Baltimore Cato 10e. Street and Number	nsville 10f. Zip Code	100	Citizen of Miles Co	
	with Sa or	Dic	717 Maiden Choice Lane	21228	109	. Citizen of What Co U.S.A.	unity :
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f ahow its Madical Examilian a	Funeral Director		I. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	rican Indian,
9	after or Ita	/ Fui	Armed Forces? 1 ☐ Never Married 2 ☑ Married If Yes, Give	1 ☐ Yes 2 ☒ No Specify:	o Hican, etc.)	Black, White	e, etc.
003	ural',	d by	3 Widowed 4 Divorced Year or Dates:			LUM	
75	in 72 1 *nat	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work . DO NOT use retired)	king 16	b. Kind of Business/	Industry
212	d with giene.	omo	Elementary/Secondary (0-12) College (1-4or 5+)	emaker		Own Home	
nd	be filed tal Hygie d other avant, II	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma	iden Sumame)	
yla	should bent a marked umetic a	To	Benjamin DeYoung		Van Dyke		
Maryland 21215-0036	12 sho hand 7 Is mu traum			Old Sundowland Doo		•	
e,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 Is marked other than "naturat, or Itams 23a or 28e-f ahow or other traumetic avant, Ire Madical Ext., institution at the millihod at			Old Sunderland Roa position (Name of ematory or other place)		c. Location - City or	
OH	Sages ent of nt: If it		I Duliai 2 (Vicionation 3 Linguioval nom state	ematory or other place) Vash.Crematory 1−3-		aurel, Mar	
Baltimore,	permit. Pages ' Department of H Important: If its any injury or ot			22. Name and Address of Facility Witzke Funeral Hom			
8	permi Depa Impo any ir		comand comment	<u>630 Edmondson Ave.</u>	<u>Catonsvi</u>	lle, Marv	inc. land 21228
П			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. End Stage	Dementia			Onset and Death
	Examiner		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
760,	ate be executed sysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):				
687	icate b	dicai	d				
Вох	es that the death certifical igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv
	death e atte	icia	in the past 12 months? 1 Vec 3 Miles 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	at the	hys	9 Unknown				
	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as it	by	Part II. Other significant conditions contributing to death but not resulting in the			cco use contribute to	the cause of death?
orc	w require been si should t	eted	Coronary Artery disease Congas tive Heat Failure				
Vital Records,	The law cate has page 2 s	Completed by	congastive Heart Fullure		24a. Was an autopsy performe	d? prior to c death?	topsy findings available completion of cause of
tal	icien: Th certificate rector, pag	Φ	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ₺ th (Check only one)	1 ☐ Yes	2 □ No
of Vi	Physicien: this certificaral director, i	To B	examiner? 1 Yes 2 Proposition Hospital: 1 Inpatient 2 ER/Outpati	Othor		e 6 Other (Spec	ufy)
O L			27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe how		
isio	Attending r death. actor: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury: At home, farm, s	M 1 Yes 2 No	20f Location (Street	et and Number or Ru	ral Bouto Mumbas
Division	i te	Certification:	4 Homicide determined building, etc. (Specify)	street, ractory, office	City or Town, S	State)	rai noute Number,
	Hospital or 44 hours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	ath occurred at the time, date and place.	, and due to the caus	se(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To To	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month	n, Uay, Year)
•			30. Name and address of person who completed cause of death (Item 23a) (Typi	D4437-	12	129 104	
			30. Name and address of person who completed cause of death (Item 23a) (Type Deneen Bowlin un 7-11 Maiden 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 4 2005	Choice Land	Cation	sville	MA 21226
	Sta	te	31. Date filed (Month, Day, Year) JAN 0 4 2005 32. Registrar's Signature	1. 6.			
	Registr	ar	JAIN U 4 ZUUD MARKE JO	MARCE !			

			_ For	State of N	Maryland		artment (gien	e	
			1 - State Registrar			Ce	rtificate	of Deat	h		Reg. J	3.004	41748
Н	Physici	an	Decedent's Name (First, Middle,	(Last)	O ima	rn V				2. Date of De	Da		3. Time of Death
3	/Medio	al	4a. Facility Name (If not institution,	give street and number	<u>ime</u>	iek	4b. City. To	wn, or Location	on of Death	Vecembe		27, 2004 County of Dea	15:25 AT
	Examir	ier	11	yland Medi	^	for		12 110	more				
	Funeral				Age (In yrs. la		If Under 1		ler 24 Hrs.	8. Date of Birt (Month, Da	h v. Year	9. Birt	tholace (State or Foreign
	Director		217-06-1002	212M 2 F	20	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		June 12,		wash:	ington, DC
	land wow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Mary P-f eh	tor	MD Howard		Cla	rksvi.	lle						1 ☐ Yes ZXXXVo
	th the	by Funeral Director	10e. Street and Number				10f. Zip Co	ode			10g. Ci	tizen of What Co	puntry?
	ath wi	rai	5804 Wild Oran				21029				USĄ		
	er de items	une	11. Marital Status	12. Was Deceder Armed Forces	s?	5. 13.	Was Decedent f Yes, specify	t of Hispanic (Cuban, Mexic	Origin? (Spe can, Puerto f	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit	
336	urs aft	by F	Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 □Yes 2√ If Yes, Give Year or Dates	s:		1□Yes 💥	No Speci	ity:			Specify: Kor	ean American
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 ehow ta Madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	tent's Usual C	occupation	net of workin	19	16b. K	(ind of Business/	
21	ithin see	npie	Elementary/Secondary (0-12)	College (1-4o	or 5+)		kind of work o DO NOT use r	retired)	OSI OI WOIKII	'y			
	filed w Hygier other th		17. Father's Name (First, Middle, L.	3		Stuc	lent	18 Mo	ther's Name	(First, Middle,		OTC	
anc	d be f	To Be	Laddie Joe Cme	•					ın Cha		Maidel	i Sumame)	
Maryland	should ind Men ind marke	ř	19a. Informant's Name/Relationshi	the latest terminal t		19b. Mailir	g Address (S				r, City	or Town, State, 2	Zip Code)
	and 2 salth a n 27 ts		Toy Douglas Kinc	er/Stepfat!	her	5804	Wild C	range	Gate,	Clarks	vil.	le, MD 2	21029
ore	of He of He fiter		20a. Method of Disposition XX Burial 2 □ Cremation	XXBemoval from State		ace of Dispo	sition (Name on natory or other	of r place)	D	ate	20c. L	ocation - City or	Town, State
Baltimore,	Pages tment of tant: If it fury or o		* 4 □ Donation 5 □ Other (Spe	ecify)	Cal	vary (Cemeter	У	January	7 1,2004	<u>Wi_11</u>	iamson (b	unty, Texas
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or items 23e or 28e-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic.		21. Signature of Funeral Service Li	censee	1.	22	. Name and A	Address of Fac	wit:	zke Fun	era.	l Homes,	Inc.
			23a. Part1. Enter the disease, or c	omplications that caus	ed the death.							ia, MD 2	21045 Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final	ily one cause on each	line.			, .					Interval Between Onset and Death
4	/Medical		disease or condition resulting in death)	Due to (or a	as a conseque	encisus():	1						5days
	Examiner		Sequentially list conditions.	b						~			
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or a	as a conseque	ence of):			1	7 1			
	axecut and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a conseque	ence of):	and the second	~-//	_//-	-//-			
8760,	Attending Physicien: The law requires that the death certificate be executed redeath. redeath. controlled this certificate has been signed by the attending physician and by the itnered director, page 2 should be detached for use as the burial-transit	icai E		d						//1			
68	rtifical ng phy as th	8	IC COMME.							1			
Вох	leath certific attending pl	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregn	nancy				23d. Date of deli Month	very Day Year
0.	at the dea by the a tached fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		ath 5□	Other (specif	5 y)				Mona	Day real
P.O.	that the ded by detac		Part II. Other significant condition	s contributing to death	but not resul	Iting in the ur	nderlying caus	e given in Par	t I.	23e. Did to	bacco	use contribute to	the cause of death?
Records,	w requires that been signed b should be deta	d b								1 🗆 Y	es 2	No 3□Pro	obably 4 Unknown
000	aw ren is bee 2 sho	Completed								24a. Was a		24b. Were au	topsy findings available ompletion of cause of
Ä	The lav ate has page 2	Eo								autop: perfor 1 Yes	med? 2 ZVNo	death?	2 □ No
Vital	ysicien: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	Hospital					ce of Death	(Check only or			
of	Physi this cral dir	P	1 No 2 No 2 No 27. Manner of Death	Hospital: 1 Inpai		R/Outpatien 28b. Time of	-		Nursing Hom	e 5 Resid	ence	6 □Other (Spec	ity)
o	ding P th. After funer	Certification:	1 □Natural 5 □ Pending 2 ☒ Accident investiga	(Month, D	Day Year)	Injury		Injury at Work? 1 ☐ Yes 2 (riverof	Ve	hick	oject was
Division	Attendi sr death. ector: A by the fu	iffica	3 Suicide 6 Could no 4 Homicide determin	t be de Blood	Injury - At hon	ne, tarm, stre		fice	2	Bl. Location (S	treet an	d Number or Ru	ral Route Number,
	itel or rs afte el Dir led in	Ser	4 G Homiolos	building, v	etc. (Specify)	Koad			C	larks wik	Pike	Ten Oak	s Road at
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director. After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best caminer: On the basis and manners	of examination	rledge, death on and/or inv	occurred at the estigation, in a	he time, date a my opinion, de	and place, a eath occurre	nd due to the c d at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	o the	Mec	29b. Signature and title of certifier				29c. Li	cense numbe	r	2	9d. Dat	te signed (Month	, Day, Year)
	/		Kathi	M Dans	3,MD		1	16688			Dec	EMBER 2	28,2004
	'n		30. Name and address of person w	no completed cause of	f death (Item 2	23a) (Type,	Print)	ND ME	DICAL	CENTE			
	7		31. Date filed (Month, Day, Year)	ST (SACT)M	LONZE, MI	DU 2	1201						
19.	Sta Registr		JAN 0 4 2	105 Jan	strar's Signatu	Spe	le .						

			For State Registrar	State of M	Maryland		artment of H tificate of I		ind Menta	l Hygier	11114	The state of the s	1749
ı	Physici /Medic		1. Decedent's Name (First, Middle, Las		Marie	Cal	vert		Mo	e of Death	Dav Ye	ear	7. Time of Death
	Examin		4a. Facility Name (If not institution, give Saint Joseph			ter	4b. City, Town, or	A TOUR	f Death OWSON		4c. County of I	Death Alti	more
	Funeral Director		219-20-7642	ex 7. / □ M 2√2 F	Age (In yrs. Ia 84	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Mo	e of Birth oth, Day, Ye 12,1	ar)	Birthplace Country) Mary	
	e Maryland Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore	10c. City	, Town or Lo]	Dundalk				Inside City Limits 1 ☐ Yes 2 ☑ No
	with th	l Dire	10e. Street and Number 8196 Midhaven Ro	ad			10f. Zip Code	212	22		Citizen of Wha nited 9	,	
336	be filed within 72 hours after death with the Maryland that Hygiene. ed othar than "natural", or Items 23a or 28a-f show event, Its Madical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decede Armed Force 1 Yes 2 [If Yes, Give Year or Date:	s? ≩ No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XX No				14. Race -		Indian,
Baltimore, Maryland 21215-0036	e filed within 72 hou al Hygiene I othar than "nature vent, II e Moulcal E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	(Give life.	dent's Usual Occupi kind of work done o DO NOT use retired	during most	of working		. Kind of Busin	ness/Indust	try
nd 2	al Hygie d othar went, II	BeC	17. Father's Name (First, Middle, Last)	12 20 20			I D C Q G I G I I	18. Mother	r's Name (First,			STT K	Jau.
ryla	2 should be to and Mental it amarked or raumatic eve	2	William Liebno			10h Mailir	ng Address (Street		arie Ani			to Zin Co.	del
Z	alth an 27 is r	1	Mrs. Dorothy Weir		ghter		Midhave				aryland		•
more,	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		te ce	metery, crer	sition (Name of natory or other place		Date 12/31/2		. Location - Cit Middle		
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licer	see		22	Name and Address Duda-Ruc 7922 Wise	ss of Facility k Fune	eral Hor	ne of	Dundal	lk, Ir	nc.
	Pnysician /Medical		23a. art 1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SEFT	IC SHO	ock_	er the mode of dyin	g, such as o	cardiac or respir	atory arrest,		Inte On	proximate erval Between aset and Death
	Examiner	er	Sequentially list conditions,	b. INTES	as a consequ BTINAL as a consecu	_ GAN	GRENE					DF	AYS .
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	day, leading to himbolate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a consequ	ence of):							
.O. Box 68	death certil e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		2 Fetal at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date of Month	-	y Year
Ω.	sign sign d be	by	Part II. Other significant conditions of RENAL FAILURE	ontributing to death	but not resu	lting in the u	nderlying cause give	en in Part I.	23	e. Did tobacc	o use contribu	te to the ca	
I Records,	The taw ate has b page 2 s	Completed		<u>-</u>				-	_	a. Was an autopsy performed	prior deal	r to comple th?	findings available etion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or	of Death (Chec				
of	ling 1. After fune	tlon; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of li (Month, i		ER/Outpatier 28b. Time of Injury	28c. Injun	4 🔲 Nui			6 ∐Other ((Specify)	
Division	al or Attancs after death	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of	Injury - At hor etc. (Specify)	me, farm, str	eet, factory, office			ation (Street or Town, St	and Number o ate)	or Rural Ro	oute Number,
	To the Hospital or Al within 24 hours after of To tha Funaral Dirac completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the be niner: On the basis and manner	of examinati	vledge, deatl on and/or in	n occurred at the time vestigation, in my o	ne, date and pinion, deat	d place, and due h occurred at th	to the cause time, date a	e(s) and manne and place, and	er as stated due to the	d. cause(s)
)	To the within 2 To tha complet	M	29b. Signature and title of certifier:	lou, r	1.4	-	29c. License			1 2	Date signed (N Cember		, Year)
	2		30. Name and address of person who	completed cause o	f death (Item	23а) (Туре,	Print)						
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4	2005	strar's Signati	ure	SLER DR	hadron of Pasters	TOVECI	i, MAR	YLAND-	Tree als have the	34

		Tor State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment of H tificate of I	lealth and M Death		giene () () [4	41750
Physic		Decedent's Name (First, Middle, Las NETTIE	() CROS	5			2. Date of Dea Month DECEMBE	Day Yea	
/Medi Exami Funeral Director	ner	4a. Facility Name (If not institution, give LAUREL REGIONAL 5. Social Security Number 414-34-0056	HOSPITAL	la <i>st birthd</i> ay) Yrs.	4b. City, Town, or LAUREL If Under 1 Year Months Days	Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day FEBRUAR	4c. County of De	ath
pu 🕽		Usual Residence of Decedent 10a. State 10b. County MD PRINCE GI		y, Town or Lo					10d. Inside City Limits
with the Marylan 3a or 28a-f show	Funeral Director	10e. Street and Number 6407 85th AVENUE	LOKOLS NE	W CARRO	10f. Zip Code 2078	34		10g. Citizen of What (
ie, way judical file in the Maryland stand 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. It is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exercities in the indiffect at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba □ Yes 2X No	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	Specify:	nerican Indian, nite, etc.
d within 72 ho giene. rr than "natur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Deced (Give life. L		ation during most of workir)		16b. Kind of Busines	s/Industry
La y allo K. L. L. Should be filed within and Mental Hygiene. Is marked other than aumatic svant, Inc. M.	To Be C	17. Father's Name (First, Middle, Last) TRUSTY COLLINS				18. Mother's Name	ARM	OUR	
C, Mc		19a. Informant's Name/Relationship (7 MARY M. CROSS/DAUG 20a. Method of Disposition	HTER	6407 8		ue New Ca	rrollto	r, City or Town, State n . Marylar 20c. Location - City o	nd 20784
t. Page thent o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fuperal Serv) Licens	Removal from State Ga	emetery, cren 1i1ee	natory or other plac Memorial	1/3/0)5	Memphis,T	ennessee
permi Depa Impo		23a. Part1. Enter the disease, or comp	lications that caused the death	74	74 Lando	ver Road	Landove	r, Marylan	
Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	nne cause on each line. Sepsis a. Due to (or as a consequence)			9 ,			Interval Between Onset and Death
Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underflying Cause, Ebisonse of injury	b. Pneumonia Due to (or as a consequence)	·					
ficate be executed physician and streets the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):					
ath certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di 9 ☐ Unknown	Ideath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	əlivery Day Year
w requires that the de been signed by the s	by	Part II. Other significant conditions co Decubitus Ulcer		ulting in the ur	iderlying cause give	en in Part I.			to the cause of death? Probably 4 □Unknown
	Completed	Renal Failure					24a. Was a autops perform	y prior to	
hysician this certif	To Be	1 105 2 <u>X</u> 100	The second second second	ER/Outpatient		4 Nursing non	ne 5 ☐ Reside	ence 6 Other (Sp	ecify)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification;	27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homiside 6 ☐ Could not be determined		28b. Time of Injury		res 2□No	8f. Location (St	ow injury occurred	Rural Route Number,
spital or nours after naral Dire		29a. Certifying Phy	building, etc. (Specify	wledge, death	occurred at the tim	ne, date and place, a	City or Towr	ause(s) and manner	as stated.
Fo tha Ho vithin 24 h Fo tha Fu	Medical	(Check only 2 Medical Examone) 29b. Signature and ottle of certifier	iner: On the basis of examinal and manner stated.	tion and/or inv	estigation, in my op	pinion, death occurre	d at the time, d	ate and place, and du 9d. Date signed (Mor	e to the cause(s)
/		# Shey 6 30. Name and address of person who co	MD PHCirc		D425	80		12-27-04	
1)	10	Parmjit Singh Au 31. Date filed (Month, Day, Year)	ijla M.D. 5632	Annapo	olis Rd #	13 Blade	nsburg,	Maryland	20710
Regist	ate rar	JAN 0 4 20	32 Registrar's Signa	x Agos	will!				

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				yland / Depa	artment of h	Health and I	Mental Hygien	วกกน	41751		
	Physici	an					2. Date of Death Month Day Year 3. Time of Death				
	/Medi	cal						December 29, 2004 8:50 A M			
	Examin Funeral	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore								
				(In yrs. last birthday)	If Under 1 Year		8. Date of Birth 12-	N/A 21-1929 th	place (State or Foreign intry)		
н	Director			77 Yrs.	Months Days	Hours Min.	12/29/1924	Ma Cou	intry) ryland		
	72 hours after death with the Maryland insturel; or itams 23a or 28e-f show these Examinations to restlike at		Usual Residence of Decedent								
		Funeral Director		10c. City, Town or Lo					10d. Inside City Limits		
			MD N/A	Baltimo					1 ☑ Yes 2 ☐ No		
			10e. Street and Number 4719 Hellwig Road		10f. Zip Code	206	10g. Ci	tizen of What Cou	intry?		
		era		orio II C 12 I	212			U.S.A.	taan ladta-		
		þ	11. Marital Status 1. Was Decedent Ev Armed Forces? 1. Never Married 2. Married 1. Was Decedent Ev Armed Forces? 1. □ Yes 2. ☑ No	I	f Yes, specify Cub	Hispanic Origin? (Si pan, Mexican, Puerto	Rican, etc.)	Black, White			
8	urs al		3 ☐ Widowed 4 ☐ Divorced		1 ☐ Yes 2 ☒ No Specify:			Specify: White			
Ö	72 hours naturel', lical Exp	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occup	pation	16b. k	(ind of Business/Ir	ndustry		
21	within 72 ho pene. r then "natur the Medical	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)			during most of world)	King				
7			12	Offi	.ce Manag			ospital			
핕	0 0 0		17. Father's Name <i>(First, Middle, Last)</i> Carl Fritche				ne (First, Middle, Maider	n Sumame)			
3	should ind Men s marks umatic	2				1	Wessel				
Maryland 21215-0036	ges 1 and 2 should it of Health and Mer If item 27 Is marks or othar traumatic		19a. Informant's Name/Relationship (Type, Print) Norman Campbell/Husband		-		ral Route Number, City Ltimore, Ma:		,		
മ്	1 and Healt em 2		20a. Method of Disposition					ocation - City or T			
Baltimore,	permit. Pages Department of H Important: If ite eny injury or ot		tx☐Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren Lorraine							
Ξ	nit. Partmen ortant: injury	1	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee				/31/04 Balt: [ller-Dippe]				
Ba	Depa Impo eny ii	l .					Baltimore, 1				
			23a. Part1. Enter the disease, or complications that caused the					laryrand	Approximate		
	Physician		23a. Part1. Enter the disease, constitutions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure last only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic Cancer with Metastsis to Live: Due to (or as a consequence of):						Interval Between Onset and Death Mos		
	/Medical								r Hos		
	Examiner		Emphysema						Yrs		
	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
	ate be executed hysician and the burial-transit	Examiner	that initiated events C.								
,092	oe execian a		Due to (or as a d	consequence of):							
	cate b	dlcal									
x 68	death certifical e attending phy id for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy								
Вох	atten for us	ian						23d. Date of delivery Month Day Year			
	0 0 2	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								
Δ.	The law requires that the tee has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco	23e. Did tobacco use contribute to the cause of death?			
Vital Records,	uires l signe	d by	1 \(\text{Yes}				1 □ Yes 2	2 No 3 Probably 4 □Unknown			
<u>o</u>	w requir been si should	lete					24a. Was an	24b. Were auto	ppsy findings available		
Be	The lavate has	e Completed					autopsy performed?	prior to co death?	mpletion of cause of		
	ding Physicien: h. After this certifics funeral director, f		25. Was case referred to medical			26 Place of Deal	1 ☐ Yes 2 ☐ No th (Check only one)	1 □ Yes	2□ No		
5		ToB	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	3 DOA Oth	ner: 4 Nursing Ho					
			27. Manner of Death 28a. Date of Injury	28c. Injur	28c. Injury at 28d. Describe how in						
Division		atio	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 287. Location (Socity or Town)								
<u> </u>	or Atten after deat Diractor: in by the	ertification;						reet and Number or Rural Route Number, . State)			
ā	itel or irs afte ral Dir led in	O									
	To tha Hospitel or Attenwithin 24 hours after deatl To tha Funaral Diractor: completely filled in by the	Medical (29a. Certifier (Check only of Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only of Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	tha I		one) and manner stated.								
29b. Signarure and title of certifier								Date signed (Month, Day, Year)			
Collen Reilley MD D54749						47	12/				
	7		30. Name and address of person who completed cause of dea Allen Reilly MD 4805 Bens	on Avenue	Print) Baltimo:	re, Marvl	and 21223				
	Sta	te	31. Date filed (Month, Day, Year) 32. Degistrar's	Signature							
	Registr		IAM 0 4 2005	. K So	ale						

			State of Maryland / Department of Health an Certificate of Death	nd Mer		gie <u>ze</u>	4	41752
	Physiciar		1. Decedent's Name (First, Middle, Last) Charlene Carroll Cooke		Date of De. Month	Day 20 (Year	3. Time of Death 1 4 0 4 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital 4b. City, Town, or Location of E	Death	ec. 2	4c. County		.1
i	death with the Maryland Time 23e or 28a-f show Times Le notified at		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours Months Days Hours	4 Hrs. 8. Min.	Date of Birt (Month, Da	h y, Year) 5,1934	Cour	olace (State or Foreign otry) yland
		tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore				1	I Od. Inside City Limits Xi ☐ Yes 2 ☐ No
		Direc	10e. Street and Number 10f. Zip Code 2535 Perring Manor Road 21237			10g. Citizen of USA	What Cour	ntry?
36	s after death , or Items 23	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 1 □ Vest Circle 1 □ Vest Circ	n? (Specify Puerto Rica	y Yes or No an, etc.)	- 14. Rad Bla	ce - Americ ck, White,	etc.
Maryland 21215-0036		Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		+ - F	16b. Kind of B Un	usiness/In	_{dustry} Memorial
land 2		To Be Co	12th grade Nursing Assistant 17. Father's Name (First, Middle, Last) Charles Hargett King 18. Mother's July			Maiden Sumar		Car
			19a. Informant's Name/Relationship (Type, Print) Joyce Jones/ Sister 19b. Mailing Address (Street and Number of 2537 Perring Management)	or Rural Ro	oute Numbe	ar, City or Town, nore, M	State, Zip aryl	code) and21237
Baltimore,			\(\frac{1}{4}\)Donation 5 \(\Delta\)Other (Specify) Maryland National Me		PK .		, Ma	ryland
Balt			21. Signature of Funeral Service Lice tee 22. Name and Address of Facility (5240 Reisterst	Chat town	man-I Rd _E	Harris Baltimo	Fun ore,	eral Home Md 21215
	Priysician		23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Probable Myoca-deal disease or condition					Approximate Interval Between Onset and Death
	ling Physicien: The law requires that the death certificate be execut. I, After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar		resulting in death) Due to (or as a consequence of):					
8760, 5		dical Examiner	Sequentially list conditions, if any, leading to immediate eause. Ellor Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
P.O. Box 68		Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 1 Compared to the pregnancy 1 Compared to the p				te of delive	ery Day Year
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			obacco use cont		ne cause of death?
il Records,		Completed		_	24a. Was autop perfor 1 Yes	rmed?	Were autoprior to condeath?	psy findings available mpletion of cause of
f Vital		To Be	25. Was case referred to medical examiner? 1 Yes 2 No			ne) lence 6 □Oth	er (Specifi	()
Division of			27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Tyes 2 No 28d. Describe how injury occurred 1 Tyes 2 No					
層	tal or Atters after de si Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (S City or Tow	Street and Numb m, State)	er or Rura	l Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director; completely filled in by the	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and occurred a	due to the out the time, o	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
	To the To the comp	Ň	29b. Signature and title of certifier Tenure Sahe 19 29c. License number 000585	70		29d. Date signe	d (Month, 1	
_	1		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	mo	wita	in t	031)1ta/
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 2005 Registrar's Signature					

			For State Registrar	State of Maryla		artment of F rtificate of			gie z e () 4	41753
	Physici		1. Decedent's Name (First, Middle, Las	nelvin 1	Ogra.	ridge		2. Date of De Month / Z	3ay	ou ou	3. Time of Death 7. 4/0rm
	/Medio Examin		4a. Facility Name (If not institution, give	e Circle		Balt	r Location of Death		4c. Cour	nty of Death	
	Funeral Director		5. Social Security Number 2,193 g 1 0 1 5 9 1 Usual Residence of Decedent	M 2 F G	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthp Cour	place (State or Foreign ntry)
	e Maryland sa-f show	Director	10a. State 10b. County	100.	city, Town or Lo	ocation					0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the name of 2	Dire	10e. Street and Number 7 \$15 \ \rightarrow \rightarrow \log 0.00	Circle		10f. Zip Code	07		10g. Citizen o	of What Cour	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. The strain at 18 marked other than "natural", or Itams 23a or 28a-f show itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Evandratic ment be neithed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	+		Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)		ace - Americ lack, White,	can Indian, etc.
21215-0036	filed within 72 hou Hygiene. ther than "nature int, I'm Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	sing	16b. Kind of		•
Maryland 2	should be filed and Mental Hyg Is markad othe aumatic avant,	To Be C	17. Father's Name (First, Middle, Last) Andrew Dand	ridge			18. Mother's Nam	e (First, Middle,	, Maiden Sum	•	
	and 2 sho ealth and I n 27 Is me		19a. Informant's Name/Relationship (19a. Informationship (19a. Inf	andridge Wife	19b. Maili 281	-	and Number or Rui		By 1 D. 1		(Code)
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, cre	osition (Name of matory or other pla	-7 -	Date	20c. Location	n - City or To	
Baltir	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen		2	2. Name and Addre	ss of Facility UC	dillsto	reenetu	mel 5	envices
	Pnysician /Medical Examiner	iner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or as a cons	nequence f):	ter the mode of dyi	2.7	or respiratory a			Approximate Interval Between Onset and Death Years
x 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transitians.	Physician/Medical Examiner	that initiated events resulting in death) Last	c							
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rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not r	resulting in the u	inderlying cause giv	ven in Part I.	23e. Did t			ne cause of death?
I Records,		Completed								D. Were auto prior to condeath? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		- Ott	26. Place of Deal		A		
of	S 0 10	atlon; To	1 Yes 2 You 27. Manney of Death 1 Yatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time of Injury	of 28c. Inju	4 🗀 languag m	ome 5 Nesi 28d. Describe			ý)
Division	o et ic	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (. City or To	Street and Nur wn, State)	mber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in the completely	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam and manner stated.	nowledge, deal ination and/or in	th occurred at the ti evestigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and r date and place	manner as s e, and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sign	ned (Month,	Day, Year)
	. 7		bleve 59	0	M-7		058893		Januar	4 3	2005
	10		30. Name and address of person who liene Browner 31. Date filed (Month, Day, Year)	1 1	Kins	Print)	North -	Broade	way	Ba	Itimae
	Sta Regist		JAN 0 4 2	005 Angistrar's Sig		and p					

		State of Maryland / Department of Health ar State Certificate of Death	nd Men		giene ()	04	41754
		Decedent's Name (First, Middle, Last)		Date of Dea Month	ath		3. Time of Death
Physician /Medical		Helen M. Dickerson			er 29,	Year 2004	8:10 P M
Examiner	r	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Death		4c. Cour	ity of Death	1
		Greater Baltimore Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	4 Hrs or	Date of Piet		Balti	
Funeral Director			Min.	Date of Birtl Month, Day	3 1944	9. Birti	nplace (State or Foreign intry) MD
D	-	Usual Residence of Decedent					
arylar ehow	_	10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
the M	9	Md Balto Owings Mills 10e. Street and Number 10f. Zip Code			10= 0:4:	() () - () ()	1 ☐ Yes 2 ☐ No
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death ms 2;	lera lera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	n? (Specify	Yes or No-	U S A		ican Indian,
after or life	2	Armed Forces? 1 □ Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, If Yes, Specify: 1 □ Yes 2 No	Puerto Hica	n, etc.)		ack, White	, etc. Black
bours trail;	0	3 Widowed 4 Divorced Year or Dates:			Spec		
2 in 15 15 15 15 15 15 15 15 15 15 15 15 15		15. Decedent's Education (Specify only highest grade completed) [Second Second			16b. Kind of	Business/l	ndustry
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aryla should the Market Individual to market Individual to market Individual to Market Indivi	0		ie Mae				
11 = 01 = 0		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Num					
re, N 1 and 1 Health 1 Health	-	Leon Dickerson - Husband 9317 Lyonswood Drawson Disposition 20b. Place of Disposition (Name of	ive (wings	20c. Location		21117 own, State
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Baltimore, permit. Pages 1 at Important: If item Important: If item eny injury or othe once.	Î	21. Signature of Saneral Service Licensee 22. Name and Address of Facility		ch F/			
™ 89 E 2 8		Jala March 4300 Wabash			Balto,	Md 2	1215
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18760, cate be except by sician at the burial-	Ľ	Due to (or as a consequence of):					
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OX (I NIMI	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. D	ate of deliv	erv
Division of Vital Records, P.O. Box 6 or Attending Physicien: The law requires that the death certificate death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as errification: To Be Completed by Physician/Me	21010	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No				onth	Day Year
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dS, ires the signed d be d		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tol 1 □ Ye	. /		he cause of death?
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al Record The law requires cate has been s page 2 should	-		-	24a. Was a autops perforr	sy	prior to co death?	ppsy findings available impletion of cause of
/ital cien: T cien: T sertificat sector, pa		25. Was case referred to medical 26. Place of			3 No	1 🗌 Yes	2 No
of Vi hysici his cer Il direc)	examiner? 1 Yes 2 No				her (Specia	(v)
In O Ing Pl Marth Uneral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Injury Work?	28d. I		ow injury occu		
tendited death the fit	2	2 Accident investigation M 1 Yes 2 No					
Division (tel or Attending P is after death. led in by the funeried in by the transfer the per present the period of the period	5	4 Homicide determined determined building, etc. (Specify)	281. [City or Town	reet and Num n, State)	ber or Hur	al Route Number,
		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	olace, and d	lue to the ca	ause(s) and n	anner as s	/tated.
o the Hosp thin 24 hou o the Funer ompletely fill		(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	occurred at	the time, d	ate and place	, and due t	o the cause(s)
To t To t Common	2	29b. Signature and title of certifier 29c. License number		2	9d. Date sign	ed (Month,	Day, Year)
8	-	D3484			12/31	100	
/ 6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAYMUND A: NOZEMD PA 7801 YORKRO#100, 700	w Firm	mn	21	204	
State					X	- /	
Registrar		JAN 0 4 2005 Some & Jane					

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 14 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Rev. Paul Francis Dolan December 2004 4:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella Maris Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 30, 1 Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days Hours Yrs July Director 216-16-6918 85 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Springs Road 21093 USA death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. be filed within 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2X No White Specify: 3 ☐ Widowed 4 ☐ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Archdiocese and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Catholic Priest Archiocese 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter F. Dolan Loretta O'Conell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 825 Wellington Road, Baltimore, MD. f Health Richard Talbott/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō Important: If it any injury or o once. 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 1/05/2005 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signate e of Funeral Service Lice 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown à n signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Tes 2 X No Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Division of this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t hours after 4 Homicide within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the

DHMH 17 Rev 1/2001

DECEMBER

Registrar

JAN 0 4 2005

29b. Signature and title of certifier

1-

DR. TARIQ MAHMOOD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Dav. Year)

			For State Registrar	c C	ertificate of L	Death		Reg. No		41/56
	Physici	an	1. Decedent's Name (First, Middle, Last)	lae Edwards			2. Date of De Month Dec.	Da	2004 Year	3. Time of Death 7:45pM
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or	Location of Death	Dec.	_	c. County of Deat	
	_ Xaiiiii	Ŭ.	33 Yawmeter Driv	re		e River			Baltimo	ore
I	Funeral		5. Social Security Number 6. Sex 1 ☐ M 3	7. Age (In yrs. last birthda RF 96 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Ye <i>ar</i>		hplace (State or Foreign untry)
_	Director		Usual Residence of Decedent	90			April	9,1	908 NO	rthCarolin
	arylan show d at	-	10a. State 10b. County MD Baltimo	10c. City, Town or	Location dle River					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M.	Director	10e. Street and Number	,TC HIG	10f. Zip Code			10n C	itizen of What Co	
	3a or	I DI	33 Yawmeter Driv	re	2122	:0		USZ		unity:
	ams 2	Funeral	A	as Decedent Ever in U.S. 1 med Forces?	Was Decedent of Hill If Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White	
20	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural; or Itams 23a or 28a-f show imatic avent, the Medical Evarinar must be notified at	by Fu	If	☐Yes ♣♠No Yes, Give ear or Dates:	_	Specify:		j	SpecifyWhi	
5	2 hou	ted	15. Decedent's Education	16a. De	cedent's Usual Occupa	tion	ina	16b. F	Kind of Business/l	
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7	filed w Hygier Sthartl	Co	17. Father's Name (First, Middle, Last)	1101	memaker	18. Mother's Name	(First, Middle			
Maryland	be partial by a sys	To Be	Stokes Childers				ie Yel		,	
<u>a</u>	2 shou and N Is mai		19a. Informant's Name/Relationship (Type, P	int) 19b. M	ailing Address (Street a					Tip Code)
	# 4 B G		Arthur Edwards /		33 Yawmet		e Balt			
panilliore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remov	cemetery, c	sposition (Name or crematory or other place leCemeter	9)			cation - City or tindbur	
	permit. Pag Department Important: I any injury c		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 	A AA		-				-
Ď	Depar Impor any ir		* R. Terry (onnelly	300	Mace A	nelly re Ba	Fun 1+i	eralHon	meofEssex
	*		23a. Part1. Enter the disease, or completion shock, or heart failure. List only one can	is that caused the death. Do bet	enter the mode of dying	, such as cardiac o	or respiratory a	rrest,	MOLG VI	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	EIMER'S	DEMENT	TIA			DAYE
		ier	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):	ell-(en 3	Parier	1/1			
	cuted nd ransit	Examiner	cause. Enter Underlyitig Cause (Disease or injury that initiated events c							
Ď,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence of):						
00/00	physicate by single the k	Aedical	d							
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5	The law requires that the de. Ite has been signed by the a bage 2 should be detached t	Phy	9 ☐ Unknown 9 Part II. Dther significant conditions contribute	ing to death but not resulting in the	A underlying cause give	n in Part !	23e. Did t	tobacco	use contribute to	the cause of death?
vital necords,	uires l signe	d by	PERIPHERNE VA							obably 4 Unknown
5	aw require s been siç 2 should b	olete					24a. Was		24b. Were au	topsy findings available
ב	The la	Completed					auto perfo	ormed?	death?	completion of cause of
	Physician: The law this certificate has by ral director, page 2 s	Be	25. Was case referred to medical examiner?	al.	0.1	26. Place of Death				
5	Phy this ral d	. To	1 ☐ Yes 2 ☑ No Hospit 27. Manner of Death 28	I Inpatient 2 EH/Outpa	tient 3 DOA Othe	f: 4 ☐ Nursing Ho	me 5 Resi 28d. Describe			eify)
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DIVISION OF	or Attano after death Diractor: in by the	Certification:	e Cloude not be	e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (City or To	Street a	nd Number or Ru	ral Route Number,
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	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	(Check only 2 Medicel Exeminer: (To the best of my knowledge, do not the basis of examination and/or not manner stated. 	eath occurred at the tim r investigation, in my op	e, date and place, inion, death occurr	and due to the ed at the time,	cause(s date an	s) and manner as id place, and due	stated. to the cause(s)
	ro tha within ? Fo the	Mec	29b. Signature and title of certifier	no maintoi statou.	29c. License	number		29d. Da	ate signed (Month	n, Day, Year)
	,- > 0		Pache MD		PSS	306		JAN	, 31d, J	L005
6			30. Name and address of person who comple DENN'S H- ODIE #1 31. Date filed (Month, Day, Year) JAN 0 4 2005	ed cause of death (Item 23a) (Type	pe, Print)	0 -	0			2
-	A 01		DENNIS H. ODIE *1 31. Date filed (Month, Day, Year)	32 Registrar's Signature	TIHA FO -	JUITE D	10 kA	U10.	170 1/2	3.7
	Sta Registr		JAN 0 4 2005	Deves At A	Jack J					

				State of Maryland / Department 1- State Registrar Certificate	t of Health and I e of Death	_	iene 2004	41757
		Physici		1. Decedent's Name (First, Middle, Last) Clara M. Eagan		2. Date of Death Month Dec. 28,		3. Time of Death
		/Medic Examin			Town, or Location of Death	1	4c. County of Death	1
	Ī	Funeral Director		Harford Memorial Hospital Ha 5. Social Security Number 6. Sex $1 - 14 - 2715$ 6. Sex $2 - 1 - 14 - 2715$ 7. Age (In yrs. last birthday) Months Months				place (State or Foreign
				Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
		Maryli a-f sho	tor	Md. Harford Bel Ai	r			1 ☐ Yes 2 🖾 No
		ath with the Marylan s 23a or 28a-f show net be redified at	Director	10e. Street and Number 10f. Zip	Code 21014	16	Og. Citizen of What Cour	ntry?
		death ims 23	nera		ETOT4 Jent of Hispanic Origin? (Spirity Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
	5-0036	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show ant, I'm Medical Ever it at Irwal be Indiffed at	Completed by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		o nicati, etc.)	Black, White, Specify: Wh	ite
8	15-0	nin 72 ha n "natu Ne Jicot	pletec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work life. DO NOT us	I Occupation rk done during most of wor se retired)	king	16b. Kind of Business/In	dustry
NaiR	12121	e filed within al Hygiene. I othar than vant, It e Me	Com	Elementary/Secondary (0-12) College (1-4or 5+) 1 homemaker		(E) . A(1) (I) A	own home	
Z	land	2 should be fi and Mental H is marked otl aumatic evar	To Be	17. Father's Name (First, Middle, Last) Nicholas Spinnato	Mary Ma	ne <i>(First, Middl</i> e, <i>N</i> Ascheri	Maiden Surname)	
X	Maryland	2 4 5 E			(Street and Number or Rubbell Road, I			
8	ore,	Pages 1 all nent of Hea nnt: If itam ury or otha		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State	ne of ther place)	Date 2	20c. Location - City or To	wn, State
(-)	Baltimor	permit. Pages Department of i Important: If its any injury or o		'4 □ Donation 5 □ Other (Specify) Highview Mem. 21. Signature of Funeral Service Licensee 22. Name and	d Address of Facility		Fallston, M	
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98		Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
35		Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	2 Pries	macia.		
30	19	executed and al-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	e heart	faili	inq	
138/	68760	ficate be executed physician and s the burial-transit	edical E	d				
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agar		ng Ph Iter th Ineral	tion:	M. M. Mariana	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho		
3	Division	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Diractor; Atter th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Rura , State)	l Route Number,
		Hospital 24 hours Funaral tely filled	ledical Co	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred a 2 ☐ Medical Examiner: On the basis of examination and/or investigation, and manner stated				
	N	To tha within. To tha comple	Med		License number		Od. Date signed (Month,	Day, Year)
		10		30. Name and address of person who dempleted cause of death (Item 23a) (Type, Print)	0001	- A .		- 1
		Sta	ate.	31. Date filed (Month, Day, Year) 32. Regionar's Signature	Unimare	Sau	redo grate	2001078
		Registr		JAN 0 4 2005 Server St. Spart	و			

Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Medical Office				1 - For State Registrar	tate of Maryl	and / Depa <i>Cei</i>	artment of F	lealth a <i>Death</i>	nd Menta	l Hygien		41758
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Social State Social State Social State Social State Angel in yet, and promoting Long Town Mortra Days Social State Social				4a. Facility Name (If not institution, give street	et and number)		4b. City, Town, or	Location of	f Death			
Discourage of the part of the												
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Physician Middlad Examinor Formula and a service and a s					ons that caused he dause on each line.	death. Do not ent	er the mode of dyin	g, such as d	ardiac or respira	atory arrest,		Interval Between
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Sequentially list conditions, if any, leading to immediate autosis. Enter Underlying cause use. Enter Underlying that infalled events in a substance of the sub				resulting in death)	Due to (or as a con			^				
Due to (or as a consequence of): Due to (or as a consequence of):			<u>_</u>	Sequentially list conditions, b	Due to lorge gase	1 - 2 - 1	Zinow	7				
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24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical evanimer? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death Shatural 5 Pending P	, C	s tha		Part II. Other significant conditions contrib	uting to death but not	resulting in the ur	nderlying cause give	en in Part I.	236	. Did tobacco	use contribute	to the cause of death?
24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical evanimer? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death Shatural 5 Pending P	ğ	equire an sig								1 ☐ Yes 2	2 □ No 3 X F	robably 4 Unknown
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25. Was case referred to medical examiner? 1		9 - 9	Eo						10	performed?	death?	
The state of the s	<u> </u>	ian: ntifica	0	25. Was case referred to medical				26. Place				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY PARTY (SAMUME 6569 NCHORLS+601 TOUSIMMS State 31. Date filed (Month, Day, Year) 10. N. O. A. 2005	>	nysio	0		Inpatient	2 ☐ ER/Outpatien	t 3 DOA Othe	er: 4 □ Nur	sing Home 5	Residence	6 □Other (Sp.	ecify)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY PARTY (SAMUME 6569 NCHORLS+601 TOUSIMMS State 31. Date filed (Month, Day, Year) 10. N. O. A. 2005	_1	pital ours a arel C		20a Cartifier 470-441-54	and To the best of	lengudo des de de				4 - 4h	- \ d	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MY PARTY (SAMUME 6569 NCHORLS+601 TOUSIMMS State 31. Date filed (Month, Day, Year) 10. N. O. A. 2005		To th withir To th comp	Me	29b. Signature and title of certifier	0		29c. License	e number		29d. D	ate signed (Mor	nth, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				1 Meteluxe	MD		10.	44	728	/	2-29	-04
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				30. Name and address of person who comp	e ed cause of death	(Item 23a) (Type,	Print)	*				TO ISGAMMO
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		MIRACI	Loch	worts	-656	90	Chon	ST	6011	21205
					32. Registrar's S	ignature Acce	E					

	Please Type or Print in Black Indelible ink. Ensure A	ill Copies Are Legible.	
For State Registrar	State of Maryland / Department of Health and N Certificate of Death	Mental Hygiene 004	4

AG		For State Registrar	State of Marylan		ertificate of i			Reg. No.)4	41759
Physic	on	1. Decedent's Name (First, Middle, Last					2. Date of Dea		Year	3. Time of Death
/Medi	cal		el P. Fuller		45 O' T	1	Decembe	er 25,	2004	10:27 A M
Examir	ner	4a. Facility Name (If not institution, give Johns Hopkins H			4b. City, Town, o Baltimo		atn		y of Death	
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	ast birthda		If Under 24 Hr Hours Mir		h	9. Birthp Cour	place (State or Foreign
Director		021-28-7057 X	ом 2□ ғ 67	Yrs.	World Days	Tiodio iviii	JUL 23	, 1937	New	York
yiand Now		10a. State 10b. County	10c. City	, Town or	Location					IOd. Inside City Limits
e Mar Sa-fst	ctor	Maryland N/A		Ba1	timore					1 XYes 2 ☐ No
with th	Funeral Director	10e. Street and Number Anchorage Marina	2501 Boston St	root	10f. Zip Code	.224		10g. Citizen of	What Cour	ntry?
ns 23	eral	11. Marital Status	12. Was Decedent Ever in U.		3. Was Decedent of H If Yes, specify Cuba		(Specify Yes or No		ce - Ameni	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene Is marked other then "natural", or Itams 23a or 28a-1 show aumatic event, the Medical Evar grant per putilised at	5	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	erto Rican, etc.)	Specia	ack, White, fy: W	_{etc.} hite
5-0 72 hc 72 hc	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. De (Gi	cedent's Usual Occup ive kind of work done b. DO NOT use retired	ation during most of w	orking	16b. Kind of E	3usiness/In	dustry
within ene.	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		e. DO NOT use retired Engineer	d)		Elect	trica	1
il Hygin	e Co	17. Father's Name (First, Middle, Last)			DI STREET	18. Mother's Na	ame (First, Middle,			<u> </u>
ylar buld be Menta Menta arked	ToB	Samuel L. Fuller				Julia	a Pirie			
Mar 12 shd n and 7 Is m		19a. Informant's Name/Relationship (T			ailing Address (Street					Code)
re, N 1 and Health tem 27 othar tr		Karin Fuller Tiff 20a. Method of Disposition	20b. P	lace of Dis	S. Ann St	-	altimore,	MD Z12 20c Location		own, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or any highty or other traumatic event, the Medical Event once.		1 Burial 2 Cremation 3 1 3 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Removal from State Mo		rematory or other place rematory,		/31/04	Balt	timor	e, MD
Baltimo		21. Signature of Funeral Service License	max mald		22 Name and Addre	ss of Facility Societ	y of Mary	land,	Inc.	
		23a. Part1. Enter the disease, or comp	Donald lications that caused the death	Do not e	299 Frede				MD 21	Approximate
Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a HYPOTHERMIA	COME	PLICATING F	ETHANOT.	TNTOXTCAT	ГТОИ		Interval Between Onset and Death
/Medical		resulting in death)	Due to (or as a consequence)			FRACTU		1011		
Examiner	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience of):						
dansit ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	_							
O, e exec an an		resulting in death) Last	Due to (or as a consequent	uence of):						
68760, criticate be executed g physician and as the burial-transit	Medical	•	d							
× 9 € 8	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		_			23d. Da	ate of delive	erv
6. Box death cert he attendin	by Physician/N	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown		3 Ectopic pregnancy 5 Other (specify)	/			onth	Day Year
that the dended by the content of the detached	Phy	9 Unknown Part II. Other significant conditions or		ulting in the	a underlying cause gry	en in Part I	23a Did to	hacco use con	tribute to t	ne cause of death?
(A) 8 50 8		Tarrit, Guidi Sigilina di Gordina del	minibating to dodin but not not	21tmg #1 tm	s underlying oddse giv	on are are a		200		pably 4 ⊡Unknown
Cord: Tw require s been sign should b	olete						24a. Was		Were auto	psy findings available
The lav	Completed	-					autop perfor	rmed?	death?	mpletion of cause of
Vital Resident The certificate har rector, page	Be	25. Was case referred to medical examiner?	(P)a-l.		0.1		eath (Check only o			
Of Phys this al di	P.	x y Yes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpat		4 Nursing	Home 5 Resid			y)
Division of to Attending Phy after death. Director: After this tin by the funeral d	Certification:	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 12-25-04	Injur 3:15A	y Wor	k? Yes 2 X ∑No	SUBJECT	FELL O	FF BO	
Oivisic or Attence after death Director: in by the	tifle	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined					28f. l oca ion (S City or Tow	tree and Numi In, State)	ber or Rura	Il Route Number,
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsicien: To the best of my kno iner: On the basis of examina and manner stated.	wiedge, de tion and/or	eath occurred at the tin investigation, in my o	ne, date and place pinion, death occ	ce, and due to the c curred at the time, c	cause(s) and m date and place,	anner as si and due to	tated. the cause(s)
To the within 2 To the complet	Ň	29b. Signature and title of certifier			29c. Licens			29d. Date signe	d (Month,	Day, Year)
			ers		O.C.M	.E.	I	Decembe:	r 26,	2004
2		30. Name and address of per on who o	ompleted cause of death (item	1 23а) (Тур	oe, Print) 111 Penn S	Streat	Rol+imar	M	1 1	21201
St		31. Date filed (Month, Day, Year)	32. Angistrar's Signa	ture	A TATE	JLI CCL,	nail IMOre	-, mary	rand_	<u> </u>
Regist	rar	JAN'042	UUS Steere	O. 1	1041)					

Amend item#4a, 10e, 19b, perFH, MD, INF, G839, 1/10/05 TF. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** George William Field 29, 2004 /Medical December D Eacility Name (If not institution, give street and number)

33 Welbrook Road

333 Wellbrook Road 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Essex Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yo 2/8/1945 6 Sex 7 Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 □ F 215-44-0326 59 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r then "natural", or Items 23a or 28a-f shov the Medical Examinar must be exittied at MDBaltimore Essex Director 1 ☐ Yes 2 🖾 No 10e Street and Number 535 Welbrook, Road 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ind Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supply Sergeant U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Figure 27 is marked of Oliver William Field Elsie M. Eckenrode item 27 is marke other traumatic 19h Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy Field/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1-05-05 rtment of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) = 0 important: It any injury o Laurel, Md. Balto-Washington Crematory permit. Departm 22. Name and Address of Facility Bradley-Ashton/Matthews 21. Signatur of Funeral Service Licenses Muca una 2134 Willow Spring Rd., Balto., Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metas fares **Physician** monte /Medical Due to (or as a consequence of): Examiner ince Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the detached 9□ Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Yes certificate has been si rector, page 2 should Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide ō Hospital 29a. Certifier tx Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause's and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

/ and manner stated Medical (Check only one) ihe i 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O 24356 December 30, 200 Concer Center 103 Frontle & 21237 ed cause of death (Item 23a) (Type, Print) William Water 0 31. Date filed (Month, Day, Year) State JAN 0 4 2005 Registrar

			For Amend Item 23a Registrar	te of Maryland / Dep. per Dr., G839, L/	artment of Health and M 4/2005 dbb Hincate of Death		2004 41761
	Physici /Medid	an	1. Decedent's Name (First, Middle, Last) EDWARD	L. FOTHERINGI	LL		3. Time of Death 18, 2004 6:13 A M
	Examin		la. Facility Name (If not institution, give street a Saint Joseph Med		4b. City, Town, or Location of Death		4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 6. Sex 12 M 2	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10-17-191	9. Birthplace (State or Foreign Country) KANSAS
	fand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	a-fsh	ctor	MD. BALTIMORE		TIMONIUM		1 ☐ Yes 💥 💢 No
	ath with the Marylan s 23a or 28a-f show ust be redited at	rai Director	10e. Street and Number 2525 POT SPRINGS	ROAD	10f. Zip Code 21093	10g. (Citizen of What Country? U.S.A.
9800	ours after de rel', or Items Exertirer r	d by Funerai	1 ☐ Never Married X X X Married X	Yes 2 No	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
Maryland 21215-0036	within ene. then "	Completed		oleted) (Give	dent's Usual Occupation skind of work done during most of work DO NOT use retired) MANAGER	sing	Kind of Business/Industry SOCIAL SECURITY ADMINISTRATION
land;	thould be filed and Mental Hygis marked other matic event, u	To Be C	17. Father's Name (First, Middle, Last) EDWARD B. F(OTHERINGILL	18. Mother's Nam MAR I	e (First, Middle, Maide E ANDERS	•
Mary	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Pr EDWARD C. FORTHERING		ing Address (Street and Number or Ru		
altimore, I	es 1 an of Heall fitem 2 r other		20a. Method of Disposition 1 □ Burial XXI Cremation 3 □ Remove 1 □ Donatjon 5 □ Other (Specify)	20b. Place of Dispo	ALLEY CROSSING CIR osition (Name of matory or other place) SERVICE CORP. 12-2	Date 20c.	Location - City or Town, State
Baltir	permit. Page Department Importent: I any injury o		21. Signature of Funeral Service Licens	2	2. Name and Address of Facility UCK TOWSON FUNERAL		1050 YORK ROAD
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not en se on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)		spiration Pneumo	nia	Onset and Death
	/Medical Examiner			Due to (or as a consequence of): 1YOCARDIAL INF	ARCTION		
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of).			
6	ficate be executed physician and is the burial-transit	Examin	that initiated events	Due to (or as a consequence of):			
68760,	icate be e physiciar s the buri	edicai E	d.				
	entifica ding ph		IF FEMALE:	ves, outcome of pregnancy			
.O. Box	The law requires that the death certif tte has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months?	Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
0	requires that been signed b should be deta	by	Part II. Other significant conditions contributi	ng to death but not resulting in the t	underlying cause given in Part I.		ouse contribute to the cause of death? 2 No 3 Probably 4XJUnknown
of Vital Records,		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vita	icien: certific rector,	Be	25. Was case referred to medical examiner?	d:	Othor	h (Check only one)	
		n: To	27. Manner of Death 28a	1 ☐ Inpatient 2 X ER/Outpatien Date of Injury 28b. Time of (Month, Day Year)	nt 3 DOA 4 Nursing ho	ome 5 Residence 28d. Describe how in	
Division	Attending I r death. ector: After by the funer	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No		
Divi	Dir	Certification:	4 Homicide determined 286	 Place of Injury - At home, farm, st building, etc. (Specify) 	reet, factory, office	City or Town, Sta	and Number or Rural Route Number, tte)
	o the Hospitel or At thin 24 hours after d o the Funerel Direct o rpletely filled in by	edical ((Check only 2 Medical Examiner: 0		th occurred at the time, date and place, ivestigation, in my opinion, death occur		
	within 2 To The	Ž	29b. Signature and title of dertifief	/	29c. License number		Date signed (Month, Day, Year)
1.5	K. H		2 1/h E1	R physician.	D 46356	DEC	ember 18, 2004
11	J. W.		30. Nam and odress of person who complet KHDSROW TOROSSI		RLER DRIVE. TOW	SON, MORY	ALAND 2120A
	Sta Hegisti		31. Date filed (Month, Day, Year) JAN 0 4 2005	32. Registrar's Signature			

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ag No	. U	U	4	

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				Registrar						Cer	incai	e or	Deain		Reg. N	ö. O		11/02
		Physici /Medic		Decedent's Nam				lck	Farrell,	Sr	٠.			2. Date of I		304	/ear	3. Time of Death 1230 р м
		Examin		4a. Facility Name (Carrol	of not institution 1 Hosp						4b. City,		r Location of Dea tminste	r	4	c. County of Car		
		Funeral Director		5. Social Security N		6. Sex	(∬M 2□F	7. Ag	e (In yrs. last birt	hday) (rs.	If Unde Months	Days	If Under 24 Hr Hours Mir		Birth Day, Yea	921	9. Birth	place (State or Foreign infry) infry]vania
		D .		Usual Residence o					T									
		nylar How		10a. State	10b. County				10c. City, Town								İ	10d. Inside City Limits
		Ma	to	Md.	Carr	oll			Mar	iche	ster							1 ☐Yes 2 ☐ No
\		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other treumetic event, the Medical Examinat must be notified at ODCE.	Be Completed by Funeral Director	10e. Street and Nu							10f. Zij	p Code			10g. C	itizen of Wh		
7		th wit	a D	2	2802 Pa	rk .	Ave.					2	21102			U.S	.A.	
177		dea	ner	11. Marital Status			12. Was De	cedent	Ever in U.S.	13. V	/as Dece Yes, spe	dent of H	lispanic Origin? (an, Mexican, Pue	(Specify Yes or lerto Rican, etc.)	No-	14. Race Black		ican Indian,
3	9	or its	F	1 Never Marr	_		f TYes	2 🗆	No			2 □ No	Specify:	, , , , , , , , , , , , , , , , , , , ,		Specify:		
W.	8	ours ral',	d b	3 ∰Widowed	4 Divorced	j	Year or	Dates:	WW II	ļ <u>.</u>		21,3110				Зреспу.	WI	ite
FARRE	21215-0036	72 h natu	etec	(Spec	15. Deceder	it's Edu st grad	cation e <i>complet</i> ed	d)	16a.	(Give I	and of wa	ial Occup ork done	during most of w	rorking	16b.	Kind of Bus	ness/l	ndustry
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	2	ygier ygier her tl	S		2	(1)		2			. Carroc	, J.	40 Matheda N	ana (Cina Mida				
2	ıno	be fi	Be	17. Father's Name										ame (First, Midd		in Sumame	,	
Z	<u>y</u>	ould Mer Marke	၉		d Farr	-								ma V. Ne				
LI AM	Maryland	2 sh and is rr reur		19a. Informant's N									and Number or F				tate, Z	p Code)
7	6	and lealth m 27 her t	1	William		rre.	LL, UI	?					Ct., B	elair,	-		7	Otata
) [ore	ges 1 I of H If ite		20a. Method of Dis 1 Burial 2		3 □F	Removal from	n State	20b. Place of cemeter	y, crem	atory or	other plac	ce) T			Location - C		
2	Ē	men men tant:		` 4 □ Donation					Dulane	y V	alle	y He	iii o Cickli o	an.3,200				
\sim	Baltimore,	Departition Depart		21. Signature of	al Service	Licens	90	1		22.	Name a	nd Addre	as of Earling	Funeral	Char	el, F	.A.	
	_	⊈ © ≅ € Ø		H	7. le	ul	ad	1	<u>'</u>	1		32	96 Char	mil Dr.	Mar	nchest	er,	Md.21102
				23a. Part1. Enter	the disease, o art failure. Lis	r compi t only o	ications that ne cause on	t cause each l	d the death. Do r ine.	ot ente	r the mo	de of dyir	ng, such as cardi	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
4		Physician		Immediate Cause disease or condition	on		. [Rei	nal Fo	aile	ire						ŀ	days
		/Medical		resulting in death)									0					
	н	Examiner		Sequentially list co	onditions.		. M.	101	ody sple a consequence	457	10	syno	lome					ma this
		P #	iner	Sequentially list co if any, leading to in cause. Enter Und Cause (Disease of	nmediate erlying	2	Due t	6 (or as	a consequence	of):		/						
		ecute and -trans	Examiner	that initiated event resulting in death)	5	1	c.	0 /05 05	a consequence	×61.							-	
P	60,	be ex		,		ı	Duo (0 (01 03	a consequence	Ji).								
	ox 68760	phys the	n/Medical			•	d											
	×	ding	/Me	IF FEMALE:		2	23c. If ves. <i>c</i>	utcome	of pregnancy							23d. Date	of deliv	/ADV
	Bo	eath atter for u		23b. Was deceder in the past 12	months?		1 □ Live	birth	2 Fetal death		Ectopic p Other (s		У			Mont		Day Year
	P.O.	the d	Physicia	1 □ Yes 2 9 □ Unknowr			9□ Uni					,,,,,,			-			
	٩	that ed by deta	l P	Part II. Other signi	ficant conditi	ons co	ntributing to	death t	out not resulting in	the un	derlying	cause grv	en in Part I.	23e. Di	d tobacco	use contrib	ute to	the cause of death?
	OS	uires sign ld be	d by	Bilater	I de	UM	l et	tus	ions A	evi	can	lial	2	1 [Yes	2 □ No 3	☐ Pro	bably 4 Unknown
	Ö	v req beer shou	ete	o C Comin	20.0	- 0	101000	1. 4.	· · L					24a. W	as an	24h W	are au	opsy findings available
	3e	has ge 2	Completed	ettus/		501	ienop	nes	alg.					au	topsy rformed?	pri	or to c ath?	ompletion of cause of
	a	T: Tr licate r, pag												1. Yes		lo 1 [Yes	2,21 No
	Z.	siciel	Be	25. Was case refe examiner?		1	Hospital:	1			-0.0	_ Oth		eath (Check onl		• 🗆	10	
	of	Phys r this ral di	P.	1 ☐ Yes 2 Z 27. Manger of Dea	No th			Inpati		ime of		28c. Injui Woi	ner: 4 Nursing	28d. Describ				ity)
	UQ	ding h. After fune	tion	1 Natural	5 🗌 Pendi	ng igation	28a. Dat (Mo	onth, Da	ay Year)	njury	м		rk? Yes 2 □No			•		
	2	deat deat ctor: y the	ica	3 Suicide	6 ☐ Could	not be	28e. Pla	ce of In	jury - At home, fa	rm. stre				28f. Location	(Street a	and Number	or Ru	ral Route Number,
	Division of Vital Records,	after Dire	Certification;	4 🗌 Homicide	deten	nined	bui	lding, e	tc. (Specify)	,		.,,,		City or	Fown, Sta	t⊕)		
	_	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	al C	29a. Certifier	1 Certifvi	ng Phy	sicien: To t	he best	of my knowledge	, death	occurred	d at the ti	me, date and pla	ce, and due to ti	ne cause(s) and man	ner as	stated.
		e Ho e Fui letely	ledical	(Check only one)	2☐ Medica	Exemi	ner: On the	basis anner s	of examination an	d/or inv	estigation	n, in my o	ppinion, death oc	curred at the tim	e, date a	nd place, ar	d due	to the cause(s)
		ro th Mithin Fo th	M	29b. Signature and	d title of certific	er 🗸		i /		2	29		se number		29d. D	ate signed	Month	, Day, Year)
		*-		1	1	cha	~ /	5	sinter	na	2	D4	3453		De	cembe	-	30,2004
		10		30. Name and add	lress of persor	who c	ompleted că	use of	death (Item 23a)	Type, I	Print)				-			
		•		V. DIXO	H KIN	6	200	N	EMORI	AL	AV	ENU	E U	DESTMI	NST	TR.	WL	21157
		Sta		31. Date filed (Moi	nth, Day You	0 4	70052	Regis	rar's Signature		Span	E				7		
		Regist	rar		At 113	7 ~	4000	De la	Address of									

			1 - For AMend Item	19a State of N	laryland format	d Ce	otr <u>pentob</u> rtificate of	lealth and Death	Mental Hy	giene	004	41763
			1. Decedent's Name (First, Middle, L						2. Date of De	ath		3. Time of Death
	Physici /Medio		John V.	Fitzgeral	d				Decemb	Day	Year 0. 2004	1524 M
}	Examir		4a. Facility Name (If not institution, g				4b. City, Town, or	Location of Dea			County of Death	
			Laurel Regional	Hospital			Lau	re1			Prince G	eorge's
	Funeral		Social Security Number 6.	Sex 7. A 1X M 2	Age (In yrs. I	•	If Under 1 Year Months Days			th	9. Birth	place (State or Foreign
h	Director		211-28-3561	ALM ZUF	67	Yrs.			Oct. 1			sylvania
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ecation				1	10d. Inside City Limits
	faryla sho	ō-			1307 0,	,	Warmins	tor				1 ☐ Yes 2 ☑ No
	28a-	Director	Pennsylvania Bu	cks			10f. Zip Code	, CCI		10a Citi	izen of What Cou	
	with with la or									Tr.		
	ns 23	Funeral	1558 Windmill Ro	12. Was Deceder	nt Ever in U.S	S. 13	Was Decedent of H	3974 ispanic Origin? (5	Specify Ves or No		nited St 14. Race - Ameri	
(0	r lter	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces	?		f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Black, White,	
9	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1□ Yes 2√√ No	Specify:			Specify:	White
21215-0036	within 72 hours after death with the Maryland one. than "natural", or Items 23a or 28a-f show the Mudical Exameter must be notified at	Completed	15. Decedent's (Specify only highest g	Education			dent's Usual Occup		4.1-	16b. Ki	nd of Business/In	
21	thin .	pge	Elementary/Secondary (0-12)	College (1-40)	r 5+)	life.	kind of work done o DO NOT use retired))	rking			
	e filed within at Hygiene. I other than vent, the Mai	00				Pa	per Cutte	er		M	anufactu	ring
nd	tat Hydrat Hydrathe	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middle,	Maiden	Sumame)	
<u>yla</u>	Men Men arke	ဥ	James	Fitzgeral	.d			Loret		c Fee	- 2	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than *natural; or items 23a or 28a-1 show other traumatic event, the Wedical Examinat must be notified at		19a. Informant's Name/Relationship				ng Address (Street a					
	1 and 2 Health iem 27 l		James G. Fitzger	ald/Son	=1			Road W	-	_		nia 18974
altimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State		ace of Dispo metery, crer	sition (Name of matory or other plac	θ)	Date	20c. Lo	cation - City or To	own, State
Ē	ment:	,	`4 □Donation 5 □ Other (Spec		West		del Crema				nton, Ma	
Bali	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lice	90500		D:	. Name and Addres	s of Facility Funeral	Home & (?rema	atory. P	. A .
_	90 F 9 9	0_0	Juanita ON	Homas	M0095	7 1	<u>411 Annap</u>	<u>olis Roa</u>	id Odent	on,	Marylan	d 21113
5			23a. Part1. Inter the disease, or conshock, or heart failure. List ont	nplications that cause y one cause on each	ed the death. line.	. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
	Pnysician	/ /	Immediate Cause (Final disease or condition	Sep	tic S	hock						Onset and Death 2 days
ľ	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):						
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/	Attending Physician: The law requires that the death certificate be executed r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriat-transit	хап	that initiated events resulting in death) Last	C. Due to (or a	s a consequ	anno of):						
8760,	be e) Ician buria	a E		000 10 (01 2	3 a consequ	61109 01).						
87	phys the	dicai		d								
9 X	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnan	nev						
P.O. Box	that the death cer ed by the attendir detached for use	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal	death 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive: Month	Day Year
Ó	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of de	aii 5_	Ciner (specify)					
۵.	that the ed by detac	h h	Part II. Other significant conditions	contributing to death	but not resul	Iting in the ur	nderlying cause give	n in Part I.	23a. Did to	bacco u	se contribute to th	ne cause of death?
Vital Records,	uires signe ld be	d by	Cardiomyopathy				, , ,					ably 4 XUnknown
Ö	w requir been si should	ete							· · · · · ·			
Re	The lay	Completed	Hypertensive Ca	rdiovascul	Lar Di	sease			24a. Was autop		prior to cor death?	psy findings available npletion of cause of
a	i cian; Th certificate rector, pag		oc M	1					1 ☐ Yes	2 🔀 No	1 🗆 Yes	¾ □ No
5	ysician; is certific director,	Be c	25. Was case referred to medical examiner?	Hospital: 1 X Inpat		7.3	Othe		ath (Check only or			
ot	Phys r this ral di	- To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Inj		R/Outpatien 28b. Time of	t 3 DOA	4 Nursing F	lome 5 Resid	_		()
on	tending Ph death. tor: After th the funeral	tio	1 Natural 5 Pending 2 Accident investigation	(Month, D	ay Year)	Injury	Work	? ′es 2 □No	Edd. Bosonbo II	ion injury	Occurred	
Division of	I or Attendir after death. Director: Af I in by the fur	Certification:	3 ☐ Suicide 6 ☐ Could not	30	njury - At hor	ne, farm, stre			28f. Location (S	Street and	d Number or Rura	l Route Number
	i gitte	erti	4 Homicide	building, e	tc."(Specify)		eet, factory, office		City or Tow	m, State)		
	To the Hospital or within 24 hours after to the Funeral Direction completely filled in the funeral or the funeral filled in the fune		29a. Certifier 1 ☑ Certifying P	hysician: To the bes	t of my know	rledge, death	occurred at the tim	e, date and place	and due to the o	cause(s)	and manner as st	ated.
	e Ho Fu Hetely	Medical	(Check only 2 Medical Exa	miner: On the basis and manner s	of examination	on and/or inv	estigation, in my op	inion, death occu	irred at the time, o	date and	place, and due to	the cause(s)
	To th To th comp	×	29b. Signature and title of certifier				29c. License	number	2	29d. Date	signed (Month,	Day, Year)
			1 1600r	an and			D2	3181		De	cember 3	1. 2004
	(0)		30. Name and address of person who	completed cause of	death (Item :	23а) (Туре, 1				ع ر	CCMDCI J	2004
	1.		R.G. Bhojraj, M		Gorman	, , ,,	,	Laurel.	Marylan	d 20	707	
	Sta		31. Date filed (Month, Day, Year)	22. Regist	trar's Signatu							
	Registra											

Amend item#20a, perFh, G839, 1/4/05 TT State of Maryland / Department of Health and Mental Hygiene O. 1. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year tnne 200L /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Bon Secours 8. Date of Birth (Mpnth, Day If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 9. B **Funeral** Months Days Hours 1 ☐ M 2 💢 F -40-4528 Yrs. Director zeora Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28e-f show wat be notified at Maryland 1 Ses 2 □ No Completed by Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Itams 23e 6 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status other traumatic avant, the Medical Ever-liner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 XXNo Specify: Specify: 3 Widowed 4 □ Divorced natural 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working A life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) min(rator 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) To Be and Mental I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter, 180 permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trau Md 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State r Surlal 2 ☐ Cremation 3 ☐Removal from State 2005 4 Donation 5 Other (Specify) Entombrent Ar Mem. Park 2 Name and Address of Facility 21. Signatu Ave. WiNorth nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart fail Immediate Cause (Final disease or condition resulting in death) **Physician** Hupoglycemia /Medical Due to (or as a consequence of): Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 2 \(\text{No} \) 1 🗌 Yes 1 TYes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Certification: To 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) MD MPH 00062183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Baltimore St; Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. pegistrar's Signature JAN 04 Registrar

			For State Registrar	State of Maryland / Dep	partment of Health and ertificate of Death	Mental Hygier	COUR 41/00
	Physic		1. Decedent's Name (First, Middle, Last)	ton George		2. Date of Death	Day Year 3. Time of Death
);	/Medi Examii		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	th	4c. County of Geath Baltimore Co.
tig.	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 12 12 12 12 12 12 12 12 12 12 12 12 12	7. Age (In yrs. last birthday Yrs.	/) If Under 1 Year If Under 24 Hr Months Days Hours Mir		ar) 9. Birthplace (State or Foreign Country) Mary and
	Maryland a-f ehow	tor	10a. State 10b. County Maryand 10h. County	10c. City, Town or to Ba/fix			10d. Inside City Limits 11 Yes 2 □ No
	th with the 23a or 284 unt be not	al Director	10e. Street and Number S610 York R	d.	10f. Zip Code 21212	10g. (Citizen of What Country? U. S. A.
9036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28s-1 show the Medicul Examirer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 22 (No Specify:	Specify Yes or No- no Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	be filed within 72 hours after death with the Marylar ntal Hygiene. so other than "natural", or Items 23s or 28s-1 show other than "natural", or Items 23s or 28s-1 show event, the Medical Examiras must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	e completed) (Giv	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) PELSO	orking	Kind of Business/Industry Fuller ton Supply
Maryland	should be filed nd Mental Hygid marked other amatic event, I	To Be (17. Father's Name (First, Middle, Last)	George	Ida	me (First, Middle, Maide	Clayton
-	s 1 and 2 should if Health and Mer Item 27 Is marks othar traumatic		19a. Informant's Name/Relationship (Ty, Ken Coulson (f	Per. Rep.) 561		altimore	, MD, 21212
Baltimore	t. Page rtment o rtant: If njury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		M.Ch. Cem. Ja.	1.4,2005	Fork, Maryland
Ä	permi Depa Impo any ir		23a. Pan J. Enter the disease, a compli	cations that caused the death. Do not en	2325 York Parties the mode of dying, such as cardia	c or respiratory arrest.	Funeral+ (remation ium, MD, 21093 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute Corebnicuscus Due to (or as a consequence of):		•	Interval Between Onset and Death M; au 4e
۵	Examiner	lner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury). Due to (or as a consequence of).			
8760,	cate be executed oblysicien and the burial-transit	ledical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
.O. Box 68	death certifi e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	sigr sigr d be	by	Part II. Other significant conditions con	tributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vita	ysician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No H	ospital: 1 Inpatient 2 ER/Outpatie		ath (Check only one)	
o uc	Attending Physician: r death. setor: After this certific. by the funeral director.		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe how inju	
	in the	Certification:	Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier Certifying Physics (Check only one)	ician: To the best of my knowledge, deat ler: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place evestigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. nd place, and due to the cause(s)
	To th Withir To th Comp	Me	29b. Signature and title of certifier		29c. License number	29d. D.	Pate signed (Month, Day, Year)
•	ĺ		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type,	D-17041 RUAD SUITE 38	. 30	1/EC 2004
	Sta	te	MARE T. LEAVEY	M9 1705 YORIC T	RUAD SUITE 38	LUTHERVILLE	EMD 21093
	Registr		JAN 0 4 200	1 Robert Me And	and b		

Amend item: 1, per phy G-840 2/1/05 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items of Manyland / Bepartment of Health and Mental Hygiene 1- For Amend Item 1 per phy G839 1-13-05 tas of Death

1- For Amend Item 1 per phy G839 1-13-05 tas of Death

1- Decedent's Name (First, Middle, Last) Doris Creenwood McLaughlin

1- Decedent's Name (First, Middle, Last) Doris D. 2- Date of Death Month Doris D. Physician GREENWOOD Year 9.20 PM DEC 9 2004 McLaughlin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6000 SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 1946 Year) 5. So 212 CU 48 W 0526 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□ M 20 F 100 Yrs. 58 212-48-0527 Director Maryland June Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28e-f show 1 Pres 2 □ No Baltimore MD NIA Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 5422 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Example once. USA xooa 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife loth Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia D Preston Sumuel Kice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oglesb Sandra Sister 809 Glenallen Balto. DR. 21229 mb 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, mo Hill * 4 □ Donation / ☐ Other (Specify) 1-6-05 21. Signature of ineral Savice Liceosee 52 Name and Address of Facility Funeral Home P.A. 270 Fredhilton Pass Balta mo 21209 23a. Patt. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or rean failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Pause (Final Priysician disease or condition resulting in death) MASSIVE PULMONARY EMBOLISM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. P detached 9 Unknown 9 Unknown ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 € Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CORONARY ARTERY DISEASE autonsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification; To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P15306 12129104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL OF MARYLAND BOURJELLY, SGOT LOCH RAVEN BLVD, BALTIMORE, MD 21239 GILBERT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 4 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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	1/ 20	П	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death		
	Physici /Medio		Lorraine Guerriero]	December	Day Year 28, 2004	1:00 A M		
	Examir		4a. Facility Name (If not institution, give street and number,		4b. City, Town, or	Location of Death		4c. County of Dear			
			4300 Pinetree Road		Rockvill			Montgome			
	Funeral Director		126-36-4814 ¹□м ²⊠F	ge (In yrs. last birthday 58 Yrs.) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, 1 01/18/19	Year) 9. Bird Od6 New	thplace (State or Foreign ountry) York		
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits		
	Mary -f she ied s	ţō	MD Montgomery	Rockville	2				1 ☐ Yes 2 No		
	r 28e	Director	10e. Street and Number	ROCKVIII	10f. Zip Code		100	g. Citizen of What Co	ountry?		
	th with	a D	4300 Pinetree Road		20853			U.S.A.			
	ems a	Funeral	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec	ify Yes or No-	14. Race - Ame			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23e or 28e-1 show eny injury or other traumatic event, the Medical Examenat retained at once.	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☒ No	Specify:	ican, etc.)	Black, Whit	a, atc. nite		
2-0	72 ho netur	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa	tion	16	Bb. Kind of Business/	Industry		
2	han "	Completed	Elementary/Secondary (0-12) College (1-4or	0+)	kind of work done di DO NOT use retired)	aring most of working		77			
7	iled w tygiel ther ti		17. Father's Name (First, Middle, Last)	Homen		40.44.4.4.		wn Home			
anc	d be finital H	Be o	Henry Cartier			18. Mother's Name (
2	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type, Print)	19h Mail	ing Address (Street a	Josephine			Tin Code l		
	nd 2 state are trau		Charles Guerriero, Husband		Pinetree :						
ē,	is 1 and 2. of Health ar item 27 is other trau		20a. Method of Disposition	20b. Place of Disp		Dat		c. Location - City or			
Ë	Page nent o nt: if		1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	oln Cremat	·	/2005 B ₁	rentwood.	Maryland		
Baltimore,	permit. Departnimporte		21. Sunature of Funeral Service Licensee	2	2. Name and Address	of Facility Simp	ole Trib	ute			
	70 F • 0		Louthy leant est		.040 Rockv	ille Pike	, Rockvi	lle, Mary	1and 20852		
r			23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final								
	Physician /Medical		disease or condition resulting in death)	ontine Cer	ebellar D	egeneratio	on		Onset and Death 7 years		
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o,	eath certificate be executed attending physician and for use as the burial-transit	Ex		a consequence of):							
68760,	ate be hysici the bu	edical	d								
			IF FEMALE:								
Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	by Physiclan/N	23b. Was decedent pregnant 23c. If yes, outcome 1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of deli	very Day Year		
Ö	the de	ysic	1 ☐ Yes 2 🔯 No 4☐ Pregnant al 9 ☐ Unknown 9☐ Unknown	time of death 5L	Other (specify)			, month	July 10ai		
ص.	that the second	A Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the u	inderlying cause giver	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?		
ds	n sign								bably 4 Unknown		
00	iw require s been sig should b	Completed					24a. Was an	24h Were aut	opsy findings available		
Re	The tay te has age 2	шo				·	autopsy performe	d? prior to o	ompletion of cause of		
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of <		To B	examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatier	Other			e 6 □Other (Spec	ify)		
0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending (Month, Da	ry 28b. Time o	f 28c. Injury a Work?		d. Describe how				
<u>S</u>	Attending or death. ector: After by the fune	catl	2 Accident investigation		M 1 □ Ye	es 2 No					
Division	I or Attendater death Director: I in by the	Certification:	4 ☐ Homicide determined 28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	eet, factory, office	28f	Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,		
	spitel nerel filled		29a. Certifier 1X Certifying Physician: To the best	of my knowledge, deat	n occurred at the time	date and place, and	d due to the caus	e(s) and manner as	hates		
	To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my opi	nion, death occurred	at the time, date	and place, and due	to the cause(s)		
	To t To t	Σ	29b. Signature and title of certifier		29c. License	number	29d.	Date signed (Month,	Day, Year)		
	(Mayou Illern	NY	D3184	0	Dec	ember 28,	2004		
	$\backslash \cap$		30. Name and address of person who completed ause of d								
			Wayne Meyer, MD, 9715 Medic	al Center	Drive #214	, Rockvil	le, Mar	yland 2085	50		
	Sta Registra	e ar	31. Date filed (Month, Day Near 0 4 2005 32. Resistra	Supplied of the supplied of th	gerte!						

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State of Manuland / Department of Hi	ealth and Mental I	-lygiene	200

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 5:30 AM Anne C. Gorleski December 30, 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1203 Pleasant Valley Drive Catonsville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yeer) **Funeral** 1 ☐ M 2 🖫 F Yrs 90 April 27,1914 Pennsylvania 189-03-1633 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hydene. Importent: If Item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, it a Medical Examinar must be routiled at once. 1 Yes 2X No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Pleasant Valley Drive 21228 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: ğ 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Sudo Katherine Niziotek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1203 Pleasant Valley Dr. Catonsville, MD 21228 Mary Ann Himmelmann (Daughter) 20b. Place of Disposition (Name of complexy, crematory or other place)
Lake View Memorial Park Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 1-3-05 Sykesville, Maryland 21. Signature of Fugeral Service Licensee) 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DECOMPENSATED **Physician** CONGESTIVE KEART FAILURE MONTHS /Medical Due to (or as a consequence of): **Examiner** THEROSCLEROTIC CARDIOVASCULAR DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medlcai the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 HO 3 Probably 4 Unknown PNEUMONIA Completed 24b. Were autopsy findings available prior to completion of cause of death? the funeral director, page 2 autopsy performed? 2 -NO 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 110 Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ascenthalcumos DEC, 3014, 2004 1)42510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. VASANTUALCUMAL, 516 ROLLING LD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001 41769 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 31, 2004 **Physician** Kell_v Mcaway Garlock, Jr. 10:47 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 15,1929 Washington DC Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Months 577-32-9974 Yrs Director Usual Residence of Decedent with the Maryland r then "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Prince George's Clinton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A. 8603 Brand Ct. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1∑Yes 2□NKorean IfYes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bank of America Accountant permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If item 27 is marked other to any injury or other treumatic event, IDs once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kelly M. Garlock, Sr. Lila B. Dirst 19a. Informant's Name/Relationship (Type, Print)

Juanita L. Garlock (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8603 Brand Ct. Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 200. Location - City or Town, State January 4, 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Clinton, Maryland 2005 21. Signature of Funeral S 22. Name and Address of Facility Lee FuneralHome, Inc. 6633 Old Alexadnria Ferry Road Clinton MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy dependant Molliter 1 ☐ Yes 2 No 26. Place of Death Check on one Be 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred al or Attending P 1 X Natural 5 Pendina after death.

Director: Aft
I in by the fun 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours at To the Funerel D 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) D24020 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 446 Branch 7 old W.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 4 2005 Registrar

Amend item/19a.perFH.G839.1/13/05 II

cian lical iner	1. Decedent's Name (First, Middle, Last)	CECILIA GARDNI	E R	2.	Date of Death Month	Day Year	3. Time of Death
		celi a	Gardner	1	December		7:15 P ^M
	4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or I			4c. County of Deat	
	1718 Kirkland Road		Dunda	1k		Baltin	ore Co.
	5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	9. Birth	nplace (State or Foreign untry)
	215-28-8825	M 255xF 74	Yrs.		ug. 7,19		nessee
	Usual Residence of Decedent 10a. State 10b. County	10c City To	wn or Location				10d. Inside City Limits
٦	Toa. State	100. Ony, 10	Wil of Ebbation				1 ☐ Yes 2½ No
ecto	Maryland Balti	more	100 7: 0-1-	Dundalk	10-	Cities	
Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry ?
2	1718 Kirkland Ro			222		nited Sta	
Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√√No	13. Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto Ric	an, etc.)	Black, White	
Dy	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1□Yes 2및No	Specify:		Specify:	White
	15. Decedent's Educ		ia. Decedent's Usual Occupa	tion	16b	Kind of Business/	
Completed	(Specify only highest grade	completed)	(Give kind of work done du life. DO NOT use retired)	uring most of working		Pipe	,
E O	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years	Bookkeeper		-	abricatio	n
a)	17. Father's Name (First, Middle, Last)	2 10010		18. Mother's Name (F			
0	Cecil Coc	hran		Bonni	e Queen		
-	19a. Informant's Name/Relationship (Typ		9b. Mailing Address (Street ar	nd Number or Rural R	oute Number, Cit	y or Town, State, Z	ip Code)
	Mrs. Gwen Barto / D	aughter	432 Essexwood	Ct. Ess	ex, Mary	land 212	221
	20a. Method of Disposition	00000	of Disposition (Name of tery, crematory or other place	Date	20c.	Location - City or	Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ly Hill Mem. (· !	2005 M	iddle Riv	ver MD
	21. Signature of Funeral Service License		22. Name and Address	of Facility			CI, IID
	Veral GV -		Duda-Ruck	Funeral Ho			nc. 21222
	23a. F. rt1. Enter the dise use, or complice shock, or heart failure. List only on	cations that caused the death. D				TYTAIIU	Approximate
	Immediate Cause (Final	e cause on each line.		Cance			Interval Between Onset and Death
	disease or condition resulting in death)	Due to (or as a consequence		conce	1		7 1100
		550 10 (01 40 4 501 504 501 10					7 715
e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				
Examiner	Cause (Disease or injury that initiated events						
Exa	resulting in death) Last	Due to (or as a consequence	e of):				
dlcal	d						
ᇴ				Action 1			
<u>e</u>	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	th 3□Ectopic pregnancy			23d. Date of deli	*
	in the next 10 months?	4 Pregnant at time of death				Month	Day Year
	in the past 12 months? 1 □ Yes 2 □ No						
	1 Yes 2 No	OL OTHEROWIT					
Physician/M	1 ☐ Yes 2 ☐ No		g in the underlying cause give	n in Part I.			the cause of death?
by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		g in the underlying cause give	n in Part I.			the cause of death?
by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		g in the underlying cause give	n in Part I.	1 ☐ Yes 24a. Was an	2 No 3 □ Pro	obably 4 Unknown
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o Be Completed by Physician/M	25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	iospital: 1 Inpatient 2 EP/0 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	Outpatient 3 DOA Time of Society	26. Place of Death (Cr. 4 Nursing Home at ? es 2 No 28f	24a. Was an autopsy performed 1 Yes 2 X Check only one) 5 Residence d. Describe how in . Location (Street City or Town, St. I due to the cause at the time, date a	2 No 3 Pro 24b. Were au prior to c 2 death? No 1 Yes 6 Other (Specializery occurred and Number or Ru ate)	topsy findings available completion of cause of 2 No sifty) ral Route Number, stated, to the cause(s)
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Function Functi			_	William Georg	e Grauer S	Sr.		_	12 - 3	25-04	91159M
Continued Cont				4a. Facility Name (If not institution,	give street and numb	per)	4b. City,	Town, or Location of Dea	th	4c. County of De	ath
Continued Cont				Franklin Square	. Hospita	al Center	Bo:	sedale		Paltimo	re
Baltimore 100 State 100 S				5. Social Security Number	S. Sex 7.	Age (In yrs. last birti	hday) If Under	1 Year If Under 24 Hr	S. 8. Date of Birth	9. B	rthplace (State or Foreign country) laryland
The Name of Agriculture 100 per control 10				Usual Residence of Decedent							
1	rylan	3	.								10d. Inside City Limits
The property of the property	. Ma 	The state of	000	MD Bal	timore	Balti	lmore				1 ∐ Yes 21‱ No
The property of the property	h with the	at be no	al Dire		t.				10g.		
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23. Part. Enter the dispase. Contribution of death Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate immediate Cause (Fifted International Cause of Research International Cause of Research International Cause (Fifted International Cause of Research International Cause (Fifted International Cause) Beauty and during in death) Beauty and during in death) Beauty and during in death (Part International Cause) Beauty and during in death) Beauty as a consequence of): Cause (Disease or condition) Cause (Disease or inting)		丑	00			N	lachinis	t		Jan Goods	3
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23a. Part : Errer the diagrams of performance has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate transfer of the diagrams of performance and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	Te, Te	otha	ď	20a. Method of Disposition		20b. Place of	Disposition (Nan	ne of	Date 200	c. Location - City o	r Town, State
23a. Part I: Free the diagrams, or performence has caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate of the cause of conditions or the cause of cause	nol not of the First	o v							/29/04 B	altimore	Marvland
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Immediate Cause (Effal disease) Immediate Cause (Immediate) Immediate Caus	Ba Permi	any i		1			6415 B	elair Road	Baltimore,	Maryland	
Security Security	760, te be executed Sician and	dical iner	ĭ	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	nas a consequence of as a consequence	on: Sp: SM TT	nbolism	27.		
Section Part	OX 68 Ox eartifica	use as th	In/Med				3 Destania ar			23d. Date of de	alivery
autopsy performed? Type 2 No Popular Pop	O. B. the death	ched for	lysicia	1 ☐ Yes 2 ☐ No	4□Pregnar	nt at time of death				Month	Day Year
Section Part	that	deta		Part II. Other significant condition	s contributing to dea	th but not resulting in	the underlying ca	ause given in Part I.	23e. Did tobac	co use contribute	to the cause of death?
autopsy performed? Type 2 No Popular Pop	ds direction	ed b	0	Sepsis					1 ☐ Yes	2 No 3 F	robably 4 Unknown
Participant of completion of cause of death? Completion of cause of death? Check only one	O. requ	hou	ete						240 1450 00	045 Wees	unter au fin die en augulahla
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Conpatient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 5 Homicide 6 Could not be determined 6 Could not be determined 7 Homicide 6 Could not be determined 8 Homicide 7 Homicide 8 Homicide 9 Ho	e faw	9 2	d l						autonsy	prior to	completion of cause of
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) Tude Moneses MD 7845 OBSWOOD Road Glen Romie, MD 21061	T. The	pag	3						1 ☐ Yes 2	No 1 ☐ Ye	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tude Muneses MD 7845 OBS WOOD Road Glen Rounie, MD 21061	/ita	ctor	O		Table 1						
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29a. Certifier (Check only one) 29b. Signature and vie of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tude Muneses MD 7845 OBS WAS	O C G	nera	ü	27. Manner of Death	(A to nih			8c. Injury at Work?	28d. Describe how	injury occurred	
29a. Certifier (Check only one) 29b. Signature and vie of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tude Muneses MD 7845 OBS WAS	pio Bridia Sath.	u) er	atic	2 Accident investiga	ation		М	1 ☐ Yes 2 ☐ No			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tude Munerel MD 7845 OBHWOOD Road Glen Parinie, MD 21061	Divis Il or Attu after de	d in by t	ertific	datamis	288. Place 0	f Injury - At home, far g, etc. <i>(Specify)</i>	rm, street, factory	, office			Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tude Munerel MD 7845 OBYWOOD Road Glen Burnie, MD 21061	e Hospita 24 hours	etely fille		29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the b xeminer: On the bas and manne	est of my knowledge is of examination and ir stated.	, death occurred d/or investigation,	at the time, date and plac in my opinion, death occ	ee, and due to the caus curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
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July Name and address of person who completed dause of death (Nem 23a) (Type, Print) Tude Muneres MD 7845 OBHWOOD Road Glen Pounie, MD 21061 31. Date filed (Month, Day, Year) 32. Medistrar's Signature				20 Name and advance			Tuno Brint'				
1 Jude VMUNESCO VILL (54) ORDWOOD FORD GIVE, MD C1061 State 31, Date filed (Month, Day, Year) 32, Megistrar's Signature	A				_		ypo, rillit)	0	1		
SELECTION OF DATA THE SELECTION OF THE S	/ \						CADM	NO LONG	PIEN 10	ornie, m	17 C1061

	1	For State Registrar		aryland /		artment of He tificate of D			Reg. No.	004	41772
Physiciar /Medica	n il	Decedent's Name (First, Middle, A. Facility Name (If not institution,	Alean G	aither -	- Gild	hrist	ocation of Deat	2. Date of De. Month Decenber	Day 28	Year 2004 County of Death	3. Time of Death
Examine Funeral Director		ST AGNES	HEALTH	ARC ge (In yrs. last 71	birthday) Yrs.		If Under 24 Hrs. Hours Min.	6	(h y, Year)	N/.	A place (State or Foreigntry) NC,
aryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo		imore				10d. Inside City Limi
hours after death with the Maryland tural', or Items 23a or 28a-f show al Examiner must be nufficed at	Funeral Director	Maryland 10e. Street and Number 2208 Chelsea Terr.	N/A			10f. Zip Code	21216		10g. Citize	en of What Cou	intry?
Traincus aries death min the maryan in natural, or thems 28a or 28a-f show olded Examiner must be nutified at	by Funera	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Tyes, 2 Tilyes, Give Year or Dates:	,		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☑ No	panic Origin? (S , Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)		4. Race - Ameri Black, White Specify:	
than "na	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or		6a. Dece (Give life.	dent's Usual Occupat kind of work done di DO NOT use retired) Postal	ion uring most of wo	rking		d of Business/li U.S. Posta	
even even	To Be Co	12 17. Father's Name (First, Middle, I Fre	ed Steele				18. Mother's Nar	me (First, Middle,	Maiden Ste		
11th ar 27 le r trau		19a. Informant's Name/Relationsh Valerie Gaither Daug				ng Address (Street ar 208 Chelsea Te					p Code)
	Ĭ	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 □Removal from State	cem	etery, cre	esition (Name of matory or other place remulen		- 05		ation - City or T	
Dapartment o Important: If any injury or once.		21. Signature of Funeral Service I	1	and the same of th	2	2. Name and Address Estep Bro 1300 Eut	others Fundaw Place	eral Home P Baltimore, M	D 2121	7	
nysician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a EMP1	d the death. I ine. 115C a consequen	AH	er the mode of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
physician and is the burial-transit	edical Examiner	Sequentially list conditions, Tary leading to mine lade cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	s a consequent		010					Unknowe
ned by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)			23	3d. Date of delin	very Day Year
engi pe q	рy	Part II. Other significant condition	ns contributing to death	but not resultir	ng in the u	inderlying cause give	n in Part I.	23e. Did t			the cause of death?
ate has been si page 2 should	Completed							24a. Was auto perfo 1 Yes	psy ormed?	24b. Were aut prior to c death? 1 \(\text{Yes}	opsy findings availa ompletion of cause of 2 No
his certifii	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		VOutpatie		r: 4 🗆 Nursing I	ath (Check only of	dence 6		ify)
after decth. Director: After in y the funera	Certification:	27. Manner of Death 1	gation not be 28e. Place of Ir	ay Year)	Bb. Time of Injury	Work	at ? es 2 \(\sum \text{No} \)	28d. Describe 28f. Location (City or To	Street and		ral Route Number,
	Medical Ce	29a. Certifier (Check only one) Certifyin	g Physician: To the bes Examiner: On the basis and manner s	of examination	edge, dea	th occurred at the tim evestigation, in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
within To the comple	Mec	29b. Signature and title of certifie		MD		29c. License	number	1		signed (Month	, Day, Year) 8, 2004
A I		30. Name and address of person PETEK DONHE	A CONTRACTOR OF A CONTRACTOR O				CATON	AVENUE	BAL	TIMORE	, HD 212
Stat Registra		31. Date filed (Month, Day, Year)	2005 Regis	trar's Signatur	· Son	dis					

DHMH 17 Rev 1/2001

CAITHER - GILCHRIST, ALEAN

			1 - For State Registrar	State of Maryla	and / Depa <i>Ce</i> a	artment of H	lealth and l Death		gier 004	41773
	Physici /Medic		1. Decedent's Name (First, Middle, Last Leroy Gill, J	•		,,		2. Date of Dea Month Dec. 23	ath Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Caton Manor Nu	· ·		4b. City, Town, o	r Location of Deat		4c. County of Deat	h
	Funeral Director		5. Social Security Number 213-30-6234 6. Se	7. Age (In y	yrs. last birthday) Yrs,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	v, Year) Co	hplace (State or Foreign nuntry) J. Carolina
	Maryland	tor	10a. State 10b. County Maryland N/A	10c.	City, Town or Lo	cation imore				10d. Inside City Limits X⊠Yes 2 □ No
	th with the 23e or 28e	ai Direc	10e. Street and Number 1309 E. Eager S	treet		10f. Zip Code 21205			10g. Citizen of What Co USa	untry?
036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show its Madical Examinar rount by mailing at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ※Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	Black, White	ncan Indian, e, etc. lack
21215-0036	d within 72 ho plene. r than "natur fire Medical	Completed	15. Decedent's Ede (Specify only highest grad Elementary/Secondary (0-12) 8th grade	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire eel Work	during most of wor d)	king	16b. Kind of Business/I	
Maryland 2	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Leroy Gill, Si	•			18. Mother's Nan	ne (First, Middle, .ce Eva.	Maiden Sumame) N.S	
, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, Ite Modical Examinational training at once.		19a. Informant's Name/Relationship (7) Lillie B. James	s/ Sister			and Number or Ru ia Aven	ral Route Numbe lue Bal	City or Town, State, Z TIMORE, Mo	3 ² 1 21 5
Baltimore,			20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ce		Tir ceneral			20c. Location - City or T Brooklyn ,	Maryland
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licens	ش						eral Home Md 21215
28760, いし	Physician and physician and physician transit the prinal-transit	edicai Examiner	23a. Part1/Enter the disease, or comp shock, or hear failure. List only o immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	TATIC sequence of):				est. E LUNG	Approximate Interval Between Onset and Death C MONTUS
P.O. Box 68	The law requires that the death certific. sie has been signed by the attending pi page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preduced in the common of the comm	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of delin Month	very Day Year
	quires that n signed by uld be deta	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to	the cause of death?
al Records,	sician: The law require certificate has been sid lirector, page 2 should b	Completed						24a. Was a autops perform	med? prior to co	opsy findings available ompletion of cause of
Division of Vital	ng Phy fter this ineral d	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 X Nursing H		ne 6 □Other (Speci ow injury occurred	(fy)
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	ecify)			City or Town		
	the Hosp nin 24 hou the Fune npletely fi	Medical	one) 2 Medical Exami	sicien: To the best of my k ner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	restigation, in my o	pinion, death occui	red at the time, d	ate and place, and due t	to the cause(s)
	To Will	4	29b. Signature and title of certifier	Vasanthal	'cuma	29c. Licens	42510	_	9d. Date signed (Month, DEC . 28 Th	Day, Year) 2004
	it		30. Name and address of person who come and Address of Person who come and Address of Person who come and the Person who come and the Address of Person who come and the Address of Person who come and the Person who come and the Address of Person who come and the Address of Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the Person who come and the P	louman,	821		UTAWS,	r, #	407 MD:	21201
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 200	32 Registrar's Sig	gnature	de s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe [] [] [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year AWTENCE 5 UNNe December 30 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MARyland BALTMORE Hospital University If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 XM 2 □ F 509-24-4018 73 Director May 18, Kansas Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow event, the Mudical Examiner must be notified at 1 ☐ Yes 2 No Gambrills Director Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 2606 Chapel Lake Dr., Apt. 409 21054 United States natural, or itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Affried Folloss: 1**XX** Yes 2 □ No If Yes, Give Year or Dates Korean 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "ne any injury or other traumatic event, the Mexit once. College (1-4or 5+) 5+ Elementary/Secondary (0-12) attorney legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aileen McComb George Gunnels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Stone Ct. Odenton, MD 21113 Warren Gunnels/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jan. 7, 2004 Pass Christian, Miss. Live Oak Cemetery Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212 21, Signature of Funeral Service Licensee Why O. Mitchell 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immadate Cause (Final disease or condition Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by ROSCLEROSIS 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an page Yes certificate Division of Vital 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 2 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Sil Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural Accident Injury 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Dire Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO040130 105 deoleur 3 10 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete DRA CHE NBER6

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Phistrar's Signature

				State of Marylar		nt of Health and te of Death		leg. No.	044	1775
			1. Decedent's Name (First, Middle, Las	()			2. Date of Dea	th		ime of Death
	Physici /Medio		James Gil	liam Ir			Month 12	Dey 26	Year 5	pm
	Examir		4e Fecility Name (If not institution, give	street and number)	/		Location of Death	4c. County	of Death	
			FutureCare			Balti			NA	
	Funeral Director		5. Social Security Number 6. Sec. 220-80-7810 19 Usuel Residence of Decedent	7. Age (In yrs.	Month	er 1 Year If Under 24 Hrs Days Hours Min		Year) 6/		State or Foreign
	aryland show	_	10a. State 10b. County	10c. Ci	ty, Town or Location		_			side City Limits ②Yes 2□No
	th the M	Director	10e. Street end Number	†		10re ip Code	1	0g. Citizen of		£169 2□140
	death with the Maryland ome 23e or 28e-f show or must be notified at	Funerai C	2700 N. C.	12. Was Decedent Ever in U	St. 13 Was Dec	2/2/8	Specify Yes or No-	14. Bac	2 SA ce - American Ind	ian
215-0020	or its	<u>۾</u>	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	ff Yes, sp	edent of Hispanic Origin? (ecity Cuban, Mexican, Puer 212 No Specify:	rto Rican, etc.)		ck, White, etc.	· K
5-0	72 hours "naturel", edicel Ex	eted	15. Decedent's Ed	ucation de completed)	16a. Decedent's Us	ual Occupation ork done during most of wo	orkina	16b. Kind of B	usiness/Industry	
2121	ges 1 and 2 should be filed within it of Health and Mental Hyglene. If Item 27 is marked other than " or other treumatic event, the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Servy	use retired)		Cater	ina S	ecuices
land	be flle tal Hyg d other	Bec	17. Fether's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Suman	ne)	CI VICE
γa	should be and Mental marked o	ဥ	James Gi	lliam >	er.	Mara	jie.	John	Son_	
Mary	d 2 should be and 7 le m		19a Informant's Name/Relationship (7)	1 - 6 1/ 11	19b. Mailing Addres	ss (Street and Number or R	1	APT T	Stete, Zip Code)	21223
-	Health Health Hem 27 other tr		20a. Method of Disposition		Plece of Disposition (No	ume of	Ore ST	20c. Location -	City or Town, St	YIQ,
Baitimore	Pa in it		1 ☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,	Hemoval from State	comotory, crematory or een Mount	Crematory	1/10/05	Bal	to. M	d.
Ball	permit. Pa Departmen Important: eny injury once.	1	21. Signature of Funeral Service Moens	iee L. R.	22. Name a	nd Address of Facility/	Funes	cal H	ome_	
		\dashv	23a. Parti. Enter the disease, or comp	lications that equised the deal	h. Do not enter the mo	de of dying, such as cardia	c or respiratory arm	301to,	Md. 2	12(6 eximate
-	Physician		shock or heart failure. List only o	ne cause on east time.		4			Onse	al Between t and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	e. Lur	g con	neur Non	Smal	1 000	L.	
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	ecuted ind transit	Examiner	Sequentially list conditions,	b. Due to (c	or es e consequence of	asiasis			1	
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68760,	ficate p phys as the	edicai	resulting in death) Lest	Due to (o	r as e consequence of)	:			į	
Вох	esu .	Σ		d						
	deati e atte	sicie	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part t.	23b. Did to	bacco use co	ntribute to the ca	auee of death?
P.0	at the d by the etach	Physician/N	And	1.			1 □ Y	s 2 No	3 Probably	4 NUnknown
	igned be d	2	- Fram	ra					1	
of Vital Records,	Attending Physician: The law requires that the death cert rideath. sctor: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use	Completed					24a. Wes a perform	n autopsy ned?	24b. Were auto available completio	prior to on of cause
Be	he law e has age 2						1 D Y	s 2XNo	of death?	2)(No
<u>a</u>	nysician: The la nis certificate has I director, page 2		25. Was case referred to medical			26 Place of De	ath (Check only on		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24 140
≥	s cer direc		examiner? 1 ☐ Yes 2 ② No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 D		dome 5□Reside		er (Specify)	
	Physical Serail		27. Manner of Deeth	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe ho			
lon	auth. or: Afte) atio	1 Naturel 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
Division	after de Directed	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street, facto	y, office	28f. Location (St. City or Town		er or Rural Route	Number,
	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physical Exami	sician: To the best of my kno ner: On the basis of examina and manner steted.	wledge, death occurred tion and/or investigation	at the time, date end place n, in my opinion, death occu	and due to the ca arred at the time, da	use(s) and ma	inner as stated. and due to the ca	use(s)
	within To the comple		29b. Signature end title of certifier	and manner stetod.	29	c. License number	2	d. Date signer	d (Month, Dey, Yo	eer)
	rsrö		PHYS!	() AN		D 57543		12-3	1-04	
			30. Neme and address of person who co	ompleted cause of death (tten SANDHV, M 32. Signistrar's Signa	1 23a) (Type, Print)	W. BAITIL	OPEC	T. R.	1 = 0 /-	A .9 . a 9 3
	Sta	e_	31. Date filed (Month, Day, Year)	32. Pagistrar's Signa	iture /	-	V ~ C 3	1 120	1210,11	U × 12×3
	Registra	ar	JAN 0 4 20	05 Stewn .	s April					
DHI	VH 16 Rev 6/95									

Amend item#19a, per INF, G839, 1/11/05 IT State of Maryland / Department of Health and Mental Hygiene 1. 1 - For State Registrar 1 776 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month JOHN HENRY HARRISON 420 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA MEDICAL CENTER BALTIMORE BACTIMORE
If Under 1 Year If Under 24 Hrs. 12 5. Social Security Number 7. Age (In yrs. last birthday Yrs. 9. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day **Funeral** 250-24-2089 1 M 2 □ F Days Hours Min. CAROLINA SOUTH Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mcdical Examinar must be routiled at 1 Yes 2 □ No Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? AIRMOUNT death Funeral SA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>y</u> Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry d 2 should be filad within 72 th and Mental Hygiene. 7 is marked other than "ne (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11+#GRADE MEATPACKING PERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TENR ္ပ 19a. Informant's Name/ elationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any njury or other traum once. 715W. SHELL GEORGE BALIO. M. 21223 FAIRMOUNTAVE. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) ROWNSVILLE CEMETERYDI - 06 05 CROWNSVILLE, MARYLAND 22. Name and Address of Hacility 21. Signature of Euneral Service Licenses JR, FUNERAL HOME BROWN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY EMBOLISM disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner DILATED CARDIOMYOPATHY YEARI Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examiner burial-transit A'BUSE ALCO HOZ YEARS attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 21 No ☐Yes 2☐No Vital Yes 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending Injury 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI P18583 ss of p who complete cause of death (Item 23a) (Type, Print) ST, BALTIMORE Kumare S. GREENE 22 KANUPRIYA 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1643 PM **Physician** 30 04 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER Chesapeake Healt AIR 1 Year HARFORD If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 9-29-1930 Months Min. 1**X** M 2□ F Days Hours 228-38-3841 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show HARFORD 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2923 (154) 21009 LANG Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
1 Nes, Give
Year or Dates: 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BIACK Completed by 3 Widowed 4 Divorced "naturel", Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) 5+ College Professor and Mental Hygie 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be lommie Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is STRATHOVEN LN Abingdon MD 21009 Mostroe Hunter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State ō 4 □ Donation 5 □ Other (Specify) Hampton Mem. Garden 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEAKD FUN eval SCK VICE and Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of) Box 68760, by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes Diractor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) JAN 0 4 2005

30. Name and address of person who

D. ANUSHA. SIRITHARA 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Hunter

2112, BELAIR ROAD SUITE 10,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 126 Maryland Physical of Health and Mental Hygiene 1 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 2004 2:05P M LIESELOTTE HINES 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL CHESAPEAKE HOSPICE HOUSE LINTHICUM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 4, 1922 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex 1 ☐ M 2 ☐ F Germany 82 165-54-5449 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Shady Side Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20764 United States 1306 Avalon Boulevard 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZHNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🖾 No Specify: Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maria Wanner Joseph Pockl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tammy Hines 1306 Avalon Blvd Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burnal 2 ☐ Cremation 3 Removal from State 2005 Ligonier, Pennsylvania Ligonier Valley Cem. 5 Cther (Specify) * 4 🗆 Don tion RTRRIEDOTTUR EUNERAL 421 CRAIN HIGHWAY S.E. 21. Signatur of Funeral Se rice Lio nsee GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or pach line. anc mont Cancer Due to (or as a consequence of): Due to (or as a consequence of):

Priysician /Medical **Examiner**

and

attending

Physician

/Medical

Examiner

Director

Funeral

ρ

Completed

Be

2

10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinating the notified at once.

Baltimore, Maryland 21215-0036

burial-transi as the use ō detached should be

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Hospitel or Attending Physicien:

After

within 24 hours after death. To the Funeral Director:

filled in by

Medical

funeral director, page 2

Examiner Completed by Physician/MedIcal Be Certification: To

Immediate Cause (Final disease or condition resulting in death) IF FEMALE 9 Unknown 1 Tyes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fusease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? No 27. Manner of Death

Natural 2 Accide 5 Pending investigation Accident 6 Could not be determined 3 Suicide 4 - Homicide

Earlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

and manner stated. 29b. Signature and title of certifier

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

9 Unknown

29c. License number D002957

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

3 Ectopic pregnancy

3□ DOA

5 Other (specify)

29d. Date signed (Month, Day, Year)

crofton, MP 2/114

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)

3 Probably

Year

4 X Unknown

Month

23e. Did tobacco use contribute to the cause of death?

1 🗀 Yes

Other: 4 Nursing Home sidence 6 Nother (Specify) Hospice
Injury at 28d. Describe how injury occurred

24a. Was an autopsy performed? Yes 2 X No

1 Yes

26. Place of Death (Check only one,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rofton BIVD STRIOI re

31. Date filed (Month, Day, Year) JAN 04 2005

and

State Registrar

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BONNIE WHEELER HANCHETT December 25, 2004 5:37am /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hours | Hour 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F North Carolina 237-38-3358 Director 80 Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes XXXVo Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6451 North Charles St 21212 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (M) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No Specify: 3XX Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "ne any injury or other traumatic event, the Medic once. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Lawrence Wheeler Ida Baucom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn H Spector DTR 21 Blythewood Road Baltimore, Maryland 21210 imore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 12/30/04 Arlington Park Atlanta, Georgia Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wielefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute.) Due to (or as a consequence of) Be Completed by Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 D No 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate KMINUN 2 No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 DNatural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. M 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m 30. Name and address of person who completed cau of death (Item 23a) (Type, Print) MOUNTY

State Registrar

31. Date filed (Month, Day, Year)

JAN 04

2005

6701

STROST

	1 - State of Maryland	I / Department of Health and Me Certificate of Death	ntal Hygiene 004 41780
Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Margaret Helen Harris	\ \ \	Date of Death Month Day Pear 2.05 A. M.
/Medical Examiner	4a. Facility Name (If not institution, give street and number) Nooth Armdel Hisphal	4b. City, Town, or Location of Death Clon ShrmE	4c. County of Death Anne Arunda
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. Ia 299–12–5879 79	st birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.	Date of Birth (Month, Day, Year) 1/25/1925 9. Birthplace (State or Foreign Country) OH
ow ow	Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Location	10d. Inside City Limits
with the Man or 28a-f sh be notified	OH Marion	Morral	1 ☐ Yes 2 No
3a or 2	3542 Marseilles-Galion Road Wo	10f. Zip Code est 43337	10g. Citizen of What Country? USA
Ind 21215-0036 be filed within 72 hours efter death with the Maryland hat Hygiene. d other than "natural", or itame 23a or 28a-1 show event, the Medical Examinar must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric 1 □ Yes 2 ☒ No Specify:	
re, Maryland 21215-0031 re, Maryland 21215-0031 8 1 end 2 should be filed within 72 hours e Heelth and Mental Hygiene. Item 27 is marked other than "natural", o other traumatic event, fre Medical Exer To Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
d 212	12 College (1-40134)	Kitchen Manager	Restaurant First, Middle, Maiden Sumame)
aryland 2 should be file is marked oth sumatic event	Floyd E. Williams		D. Rosebrough
Maryla Maryla d 2 should th and Men traumetic traumetic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural R	and the same of th
O 0 0 = =	1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State	ace of Disposition (Name of metery, crematory or other place) Ohio Cremation 1/6/20	233 Essaion Sily St. Form, State
Baltime Bernit. Pag Depertment Important: I	21. Signature of Funeral Service Licensee Mol3	22. Name and Address of Facility Sin	ngleton Funeral Home, P.A., Glen Burnie, MD 21061
- Shurdisian	23a. Part1. En er the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	×_1	
Physician /Medical Examiner	disease or condition resulting in death) Due to tor as a conseque	nce of):	8
Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen		
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examit	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetel of 4 □ Pregnant at time of dea	death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Cords, P wrequires that been signed to should be dete	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
of Vital Records, Physician: The law requires to this certificate has been signeral director, page 2 should be e.; To Be Completed by			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital Physician: or this certifical shall director,	27. Manner of Death 28a, Date of Injury 2	28b. Time of 28c. Injury at 28d	Sheck only one) 5 Residence 6 Other (Specify) Describe how injury occurred
Division of to attending Faffer death. Director: Affer din by the funer ertification:	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	M 1 Yes 2 No	Location (Street and Number or Rural Route Number, City or Town, State)
Div he Hospitel or A in 24 hours after he Funerel Direc pietelly filled in by edical Certifi	29a. Certifier Certifying Physician: To the best of my know	ledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated.
To the Hos within 24 h To the Fur completely	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
6	Anto MD	D43977	December 31 2004
() D	20 Name and address of person who completed cause of death (from 2	23a) (Prop. Print) Ulen Rymit	. mo. 2061,
State Registrar	31 Date filed (Month, Day, Year) JAN 0 4 2005 37 Registraks signary		

Amend item#8, perrh, 6839, 1/4/05 IT State of Maryland / Department of Health and Mental Hygiene OL; 1 - For State Registrar Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2004 Monfred Hughes ecenser-/Medical City, Town, or Location of Death give street and number 4c. County of Death 4a. Facility Name (If not institution, **Examiner** Sultimute, Millinder 1 Year | If Under 24 Hrs. HealthCare Mr Date of Birth 8/25/192irnplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 108 M 2□ F Hours 81 212-28-2308 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at Baltimore 1 Yes 2 No MD NIA Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21229 WALNUT AVENUE 1001 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Mayes 2 No f Yes, Give ∕ear or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. City DRIVER Baltimore NIA Stharade 17. Father's-Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental h Hughes Robinson Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 1001 Walnut Avenue Baltimore MD 21229 Ida M. Hughes WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State ä Barrism Forest DI. 10. D5 DWINGS MILE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
SIST Paltimore National Pike Baltimore, MD 21229 21. Signature of Funeral Service Licensee any ir Day 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last -transit Due to (or as a consequence burialphysician Physician/Medical the attending I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 X No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 2 No To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after Certifying Physicias: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 29d. Date signed (Month, Day, Year) 29b. Signature and le of celtifier 29c. License number cause of death (Item 23a) (Type Print) Rhac 31. Date filed (Month, 9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 10 4 782 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month DEC. Year 25 SSOLOPHUBEY 200 aR 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Bertimore Inder 1 Year If Under 24 Hrs. TENDED CAVE CENTER SCY Rehabilitation Ex N A 7. morE 8. Date of Birth Month, Day, 12.08. Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 218-58-4193 1 MM 2□F MD Yrs. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No BALTIMORE WD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1230 CLEVELAND STREET USA 21230 12. Was Decedent Ever in U.S. Armed Forces? 1 LYes 2 □ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0 ADMINISTRATOR 12 TH GRADE RECOVERY NETWORK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) VENABLE WINSTON STOKES MARGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARSHA FRIEND-GREENIDGE 1802 SURREY CT., VIERA FL 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Hurial 2 □ Cremation 3 □ Removal from State 01.05.05 BALTO. MO ARBUTUS * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee VAUGHNADOR SERVICE 5151 BAUTO. NATE PIKE, BAUTO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung CANCEL YEars disease or condition resulting in death) Due to (or a faconsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No 24a. Was an autopsy performed? 1 Yes 2₩No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28c. Injury at Work?

Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Physician/Medical for signed t d be deta Division of Vital Records, Be Completed by page 2 should certificate Hospital or Attending Physician: Medical Certification: To After

death.

within 24 hours after deat To the Funeral Director:

npletely

2 6

Box 68760,

P.O. I

Physician

/Medical

Examiner

Funeral

Director

f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itame 23a or 28a-1 shov other traumatic avant, Ita Medical Examt as must be avaitified at

ō Department of important: if any injury or once.

Pnysician

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or Itame 23.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

2

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending

investigation

6 Could not be determined

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Do015698 marin W. coa u.D.

29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Roven Boulevard, Battimero, My 3900 GALICIA inD. 31. Date filed (Month, Day, Year)

JAN 0 4 2005 Registrar

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

(Check only one)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 60 0 1.

	1 - State Registrar Ce	artment of Health and Mental H rtificate of Death	Reg. No.
Physician /Medical	1. Decedent's Name (First, Middle, Last) Margaret M. Hayes	2. Date of I Month Decemb	Day Year
Examiner	4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death Timonium	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 084-14-4458 Usual Residence of Decedent 6. Sex 1 M 2 K F 83 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of E (Month, I April 1	Birth Day Year) 9. Birthplace (State or Foreign Country) New York
a-f show	10a. State 10b. County 10c. City, Town or Lo MD Baltimore Towson	cation	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
6 after death with the Mar retems 23a or 23a-f st references to confilled Funeral Director	10e. Street and Number 1215 Limekiln Road	101. Zip Code 21286	10g. Citizen of What Country?
ours after des real, or Items Evanifier in 1 by Funer	1 Never Married 2 Married 1 Tes 2 X No	Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🌠 No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanfred matter rotified at To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedency (Give life. I	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry Internal Revenue Service
yland ould be file Mental Hy arked oth artic event.	17. Father's Name (First, Middle, Last) Kieran Dunne	18. Mother's Name (First, Middle Mary Hanlon	le, Maiden Sumame)
Mar and 2 sho ealth and n 27 Is m	Patricia E. Graff / daughter 1215	ng Address (Street and Number or Rural Route Num Limekiln Road; Towson,	ber, City or Town, State, Zip Code) MD 21286
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other traumatic event, the Me	'4 Donation 5 Other (Specify) Long Island	sition (Name of Date natory or other place) Nat Cemetery 1/5/05	20c. Location - City or Town, State Long Island, NY
Balt permit Depart Import any in	Ru Ru	. Name and Address of Facility ICK Towson Funeral Home	1050 York Road Towson, MD 21204
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	er the mode of dying, such as cardiac or respiratory.	arrest, Approximate Interval Between Onset and Death
physicien and the burial-transit	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of):		
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**** (C) C).		24a. Was auto peri 1	
To To	25. Was case referred to medical examiner? 1 Yes 2 No		one)idence 6 _Other (Specify)
Oin ding After funer	27. Manner Death 1 Platural 5 Pending 2 Accident 3 Suicide 4 Homicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work? M 1 ☐ Yes 2 ☐ No	how injury occurred (Street and Number or Rural Route Number, wn, State)
Hospi 24 hou Funer tely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, and due to the estigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
8	30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) Street Street	1 Nellinice Pop 2,230
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	U	101710000

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	Examir	ner	4a. Facility Name (If not institution, g Laurel Regional I 5. Social Security Number 6.	Hospital	r) ge (In yrs. last birthd	Laure	el	cation of Death Under 24 Hrs.	0.0-1-1/0:40		e Geo	
	Funeral Director		077–84–2470 Usual Residence of Decedent	1 ∑ M 2□F	51 Yrs	Months		ours Min.	8. Date of Birth (Month, Day June 24,	1953	Jamaic	lace (State or Foreign try) Ta, WI
	Maryland	tor	NY 10b. County Kings		10c. City, Town of New Yo			-			10	0d. Inside City Limits 1 XYes 2 No
	th with the 23e or 28	al Director	10e. Street and Number 1305 East 83RD St	reet		10f. Zip 11	Code .203		1	10g. Citizen of \	What Count	try?
920	n 72 hours after death with the Maryland "natural", or items 23e or 28e-f show odical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Yourced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	3. Was Deceding Yes, special Yes 2	ity Cuban, M	nic Origin? (Spe lexican, Puerto pecify:	cify Yes or No- Rican, etc.)		e - America ck, White, e	etc.
Maryland 21215-0036	within ane. then "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12		(G	DO NOT us	k doné durin	n g most of workii	ng	16b. Kind of B	usiness/Ind	ustry
land;	should be filed of Mental Hygis marked other	To Be C	17. Father's Name (First, Middle, Las Richard Jan	-			18.	Mother's Name Gladys	(First, Middle, I	Maiden Suman	ne)	
	and 2 sho salth and N n 27 Is ma er treuma		19a. Informant's Name/Relationship Claudette James	(Type, Print) / Sister	19b. M	ailing Address 5 E. 40t	(Street and I h Stree	Number or Rura et Brook]	i Route Number Lyn, NY 112	; City or Town, 203	State, Zip	Code)
Baltimore,	Pages 1 and 2 should beneficed the property of Health and Mentiant: If item 27 Is marked jury or other treumatic e		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		20b. Place of Discemetery, of Greenwood	rematory or oti	her place)			20c. Location - Brooklyn,		wn, State
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee		22. Name and Charl 1501	Address of ES L. S East Fo	Facility Stevens Fu ort Ave Ba	neral Hor altimore N	me Inc. Vai 21230		
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on of Vital	ding Phys h. After this funeral di	tlon: To Be	25. Was case referred to medical examiner? 1 Xes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D	ury 28b. Time	of 28	Other	Nursing Hom	Check on one ne 5 Aeside 8d. Describe ho	nce 6 🗆 Othe		
Division	al or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not determined	be 28e. Place of Ir	jury - At home, farm, tc. (Specify)			_	8f. Location (Str. City or Town	reet and Numbe , State)	er or Rural i	Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director:	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	Physician: To the besi aminer: On the basis and manner s	of examination and/or	ath occurred a investigation, i	t the time, da	ate and place, a n, death occurre	nd due to the ca d at the time, da	use(s) and mar ite and place, a	ner as stat	ted. he cause(s)
)	To the I within 2 To the Complet	Me	29b. Signature and title of certifier	I por in -	Pall 1.	29c.	License num			od. Date signed		
	3		30. Name and address of person who	completed cause of					timore,			
14	Sta Registr	_	31. Date filed (Month, Day, Year)	4 2005 ► A	ar's Signature							

			For State Registrar		ryland / Depa	artment of F		Reg. I	io 4 l	1785
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, L CY YS Tal, 4a. Facility Name (If not institution, gi HOWAYA COLLNTY	c Jone		4b. City, Town, o	r Location of Death	12 2	Day Year 200 4 4c. County of Deat How a	h /
	Funeral Director				(In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Yea 09/09/ 1		hplace (State or Foreign untry)
	r 28e-f show	rector	10a. State 10b. County MD Howard 10e. Street and Number		10c. City, Town or Lo	10f. Zip Code		10g. (Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 💆 No untry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other treumatic event, the Madical Examinar must be notified at ADGE.	d by Funeral Director	5064 Dry Well Con 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	0	21045 Was Decedent of Hif Yes, specify Cubin	lispanic Origin? (Spe an, Mexican, Puerto <i>Specity:</i>	I	ISA 14. Race - Ame Black, White Specify: Wh	ncan Indian, a, etc.
d 21215-0036	filed within 72 h Hygiene. other than "neti ent, the Medica	e Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 11. 17. Father's Name (First, Middle, Las	rade completed) College (1-4or 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired e Managei	during most of worki	ng	Shoe Shoe	Industry
Maryland	12 should be and Mental I s marked o	To Bo	Carl Harold Olso	(Турө, Print)			Amanda Os	sberg Il Route Number, City	or Town, State, Z	Tip Code)
Baltimore, I	Pages 1 and thent of Health tant: If item 27 jury or other tr		Sandra Robillard, 20a. Method of Disposition 1 □ Burial 2XXCremation 3 `4 □ Donation 5 □ Other (Special Control of Con	□Removal from State	20b. Place of Disponsion Commetery, cremetery, cremetery, cremetery, cremetery, cremetery, cremeters, constitution of the comments of the comm	sition (Name of matory or other place ashington C	rem. 01/02	/2005 Laı	Location - City or	
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or cor	nplications that caused to	the death. Do not ent	555 Twi n	Knolls Ro	zke Funera bad, Colum or respiratory arrest,	al Homes, bia, MD 2	21045 Approximate
	Physician /Medical Examiner	er	snock, or hear failure. List onf Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Chronic Due to (or as a	c obstructions of the consequence of:	0	lmonary	Disease		Interval Between Onset and Death 5 4/5
,0928	Attanding Physician: The law requires that the death certificate be executed rideath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	U	consequence of):	arl ta	iluse_			5 yrs
P.O. Box 6	that the death certific led by the attending p detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Petal death 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ords, F	w requires that been signed t should be deta	Completed by P	Part II. Other significant conditions Atrial fubril	contributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	1 Pres	2 □ No 3 □ Pro	the cause of death?
of Vital Records,	ician: The law certificate has I rector, page 2 s	a	25. Was case referred to medical				26. Place of Death	24a. Was an autopsy performed? 1 Yes 2	prior to death?	topsy findings available ompletion of cause of
ion of V	To the Hospital or Attanding Physician: The I within 24 hours after death. To tha Funerel Director: After this certificate hat completely filled in by the funeral director, page	atlon; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation			28c. Injur Wor	er: 4 🗆 Nursing Hor	me 5 Residence 28d. Describe how in		ify)
Division	To the Hospital or Attanc within 24 hours after death To tha Funerel Director: completely filled in by the	al Certification;	3 Suicide 6 Could not determined				li.	28f. Location (Street and City or Town, Sta	ite)	
	To the Hospital or within 24 hours afte To tha Funerel Dir. completely filled in the complete of the transfer	Medical	29b. Signature and title of certifier Auser Ah	and manner state	examination and/or inv	vestigation, in my o	pinion, death occurre a number	ed at the time, date a	nd place, and due late signed (Month	to the cause(s)
	5		30. Name and address of person who Kaser A Ahmad	completed cause of dea	ittle Patri	Print) Pa		columbia		
DH	Sta Registi MH 17 Rev 1/2	ar	31. Date filed (Month, Pay, Year)	2005 32. Registrar	s Signature	rester				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State Registrar 04 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician December 31. Antonio Jones Romanio 2004 1:27 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Johns Hopkins Bayview Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, May 7, 1974 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1**X**M 2□F 212-90-6127 30 Yrs. Director Maryland Usual Residence of Decedent Maryland 10c, City, Town or Location 10a State 10h County 10d. Inside City Limits r Items 23e or 28e-f shov it er wast be rediffed at 1 X Yes 2 No Maryland **Baltimore** Essex the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ā 7 Norham Court 21221 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 XNever Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15 Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other than 12th grade Retail Salesman Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental Jones James Α. Beverly. Walker ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health lam 27 Beverly Thomas Frazier (Mother) 1701 Eutaw Place; Apt. 620; Baltimore, Maryland 21217 other tam 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If its any injury or ot oncs. XBurial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion Cemetery Jan. 6,2005 Lansdowne, Maryland ⁴ □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee ²² Name and Address of Facility W. Wesley Chavis III Funeral Services, Inc. a 1. W 1722 North Capitol Street, N.W.; Wash.D.C. 20001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wound Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed transit that initiated events resulting in death) Last Due to (or as a consequence of): burial-t P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign. þ 1 Yes 2 No 3 Probably 4 □Unknown is need should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No Division of Vital Attanding Physician: 25. Was case referred to medical examiner?

12 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ← ER/Outpatient 3 ☐ DOA Other: ပ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After funer 1 Natural 5 Pending 1 ☐ Yes 2 📉o death. 12:40 AM Subject Shot investigation 12/3/04 2 Accident after death the 6 Could not be Suicide 28f. Location (Stre t and Number or Rural Royte Number, City or Town, State) 8247 Eastern Ne 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide 0 IN arinking establishment within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) Iha 29c. License number 0 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. December 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

04

111 Penn Street, Baltimore, Maryland 21201

				artment of Health and Menta rtificate of Death	Hygiene 004 41787
	Physici /Medi		1. Decedent's Name (First, Middle, Last) William Franklin	T Mo	te of Death Day Year 3. Time of Death October 25, 2004 7:00AM M
t.	Examir		4a. Facility Name (If not institution, give street and number) 127 Marmony Way 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death Centreville If Under 1 Year If Under 24 Hrs. 8 Death	4c. County of Death Queen Anne's
	Director		578-16-7356	Months Days Hours Min. Sep	ot. 17,1920 Washington, DC
	the Maryla 28a-f ehov	Director	Maryland Prince George's 10c. City, Town or L	Camp Springs	10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country?
	h with 23£ or		7003 Old Branch Avenue	20748	U.S.A.
036	iled within 72 hours after death with the Maryland Hyglene. Ither then "naturel", or Items 23s or 28s-f show ont, the Mcdical Examinar must be recitified at	by Funeral	1 Never Married 2 NM Married 1 Never Married 2 No 1942	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
1215-0036	within 72 ho one. then "natur ie Mcdical i	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Senice Senice	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
Maryland 2	be de la la la la la la la la la la la la la	To Be Co	17. Father's Name (First, Middle, Last)	or Buyer 18. Mother's Name (First, Unknow	Southern Rail Road Middle, Maiden Sumame) IR
	nd 2 salth ar 27 ls r treu		19a. Informant's Name/Relationship (Type, Print) Reta Joy (Wife) 19b. Maili 7003	ng Address (Street and Number or Rural Route 3 Old Branch Avenue Ca	Number, City or Town, State, Zip Code) amp Springs, MD 20748
Baltimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		'4 □ Donation 5 □ Other (Specify) Maryland	veterans Cem. Name and Address of Facility Veter Face Face Face Face Face Face Face Face	Cheltenham, Maryland uneral Homee, Inc.
n	80 E 8		23a, Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	6633 Old Alexandria er the mode of dying, such as cardiac or respir	Ferry Road Clinton, MD2073 atory arrest, Approximate Interval Between
,007,00	bean signed by the attending physician and should be detached for use as the burial-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	Arrest May alkan	szelozes
O. Box o	the death certiff by the attending ached for use as	Physiclan/Me		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
cords, r	The law requires that the ite has been signed by thoage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I. 236	a. Did tobacco use contribute to the cause of death? XXYes 2 □ No 3 □ Probably 4 □Unknown
	n: The faw r ficate has be or, page 2 sh	e Completed	Benight Published Hoppe 25. Was case eferred to medical	ntrophen 10	a. Was an autopsy performed? Yes 277No 1 Yes 2 No
VISIOII OI VI	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatien 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		ran laughter's Residence 6 Friner (Specific Residence coursed Residence coursed Residence
	vital or Attures after de ral Directo	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuilding, etc. (Specify)	City	ation (Street and Number or Rural Route Number, or Town, State)
	o the Hosp ithin 24 hou o the Fune empletely fi	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invane) 29b. Signature and tithe of certifier	occurred at the time, date and place, and due restigation, in my opinion, death occurred at the 29c. License number	o time, date and place, and due to the cause(s)
	111		30. Name and address of person who completed cause of death (Item 23a) (Type,	D02259	Jan 3 2005
	Sta	e .	Rene Grace, M.D. 9131 Piscataway Roa 31. Date filed (Mpqth, Day, Year) Registrar's Signature	d Clinton, Maryland 20	0735
	Registra	à	JAN 0 4 2005	100	

	1- State of Maryland / Department of Health and Mental Hygiene 0 4 788 Certificate of Death Reg. No.													
	Physici	an	N. N.							2. Date of Deat Month	Month Day Year			
	/Media	al	4a. Facility Name (If not institution	4b. City. Town.	4b. City, Town, or Location of Death				4c. County of Death					
	Examir	er	2005 Dineen D	Dundalk				Baltimore						
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday,		If Unde	r 24 Hrs.	8. Date of Birth (Month, Day,			rthplace (State or Foreign ountry)	
	Director		318-22-3426	1 □ M 2½ F	78	3 Yrs.	Wionuis Days	110013		Oct. 29			linois	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent; If item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumatic event, If a Maraical Extending rough by multiped 31 once.	Director	Usual Residence of Decedent 10a. State 10b. County		10c	. City, Town or L	ocation						10d. Inside City Limits	
			Maryland Baltimore Dundalk 1□Yes 2√2N									1 ☐ Yes 2√∑No		
											0g. Citizen o	Citizen of What Country?		
			2005 Dineen I	2005 Dineen Drive								d st	ates	
		Funeral	11. Marital Status	12. Was Dec Armed F	orces?	in U.S. 13.	Was Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R			ify Yes or No- ican, etc.)		 Race - American Indian, Black, White, etc. 		
38	irs aft	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	led 1 ∐ Yes If Yes, G Year or I		ļ	1□Yes 🖳 No	Specify	<i>y</i> :		Spec		2 .	
ğ	d be filed within 72 hountlal Hygiene. ed other then "neture: event, it a M. dic	ted	15. Decedent's Education (Specify only highest grade completed)			16a. Dece	a. Decedent's Usual Occupation (Give kind of work dope during most of working					White Sb. Kind of Business/Industry		
2		To Be Completed by	Elementary/Secondary (0-12)	kind of work done during most of working DO NOT use retired)										
2			10 Years 17. Father's Name (First, Middle,	(a at)		Но	usewife	40.14-11	- d- NI	(Final A (in the same in the s		n_Ho	me	
auc			Antonio Salva							(First, Middle, A		me)		
Maryland 21215-0036	should nd Me mark matic		19a. Informant's Name/Relations		_	19b. Maili	ng Address (Stree			eth O'N		n. State.	Zip Code)	
	alth al		Mary Ann Jacob	o / Daugh	ter		Dineen I						21222	
altimore,	es 1 a of He of He fitem		20a. Method of Disposition	2 Pomoval from	ł	b. Place of Dispo	osition (Name of matory or other pla	ice)	Da	te 2	20c. Location	- City or	Town, State	
Ĕ	permit. Page Department of Importent: If any injury or once.		1 ☐ Burial 2 ☑ Cremation `4 ☐ Donation 5 ☐ Other (S)			Iilltop	Service (Corp	12/30	/2004	Tows	on, i	Maryland	
Balt			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc.											
	Physician /Medical Examiner	Iner	7922 Wise Ave. Dundalk, Maryland 21222											
			shock, or heart failure. List				er the mode of dyl	ng, such as	s cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death	
			disease or condition resulting in death)		OTENS		-1					-		
					Due to (or as a consequence of): b. VOLUME DEPLETION								I WEEK	
			if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):										
	ecute and -trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ev or								WEEK	
8760,	ficate be executed physician and is the burial-transit	al E	, , , , , , , , , , , , , , , , , , ,	Due to	(or as a con	sequence of):								
289	ficate physis the	edical		d										
ROX	death certifi e attending I id for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Da	3d. Date of delivery		
	0 0	slcia	in the past 12 months? 1 ☐ Yes 2 ♣ No	4□Preg									Month Day Year	
J.	at the ded by the detached	l by Physician/Me	9 Unknown											
JS,	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
Ö		etec												
Hecords ,	0 = 0	Completed						·		24a. Was an autopsy perform	,	prior to death?	itopsy findings available completion of cause of	
Vital	ing Physician: After this certifi uneral director.	Be Co	25. Was case referred to medical					26 Place	e of Death /		⊠No	1 🗆 Yes	2 No	
		To B	25. Was case reterred to medical examiner? 1 Yes 2 No											
n of		Certification; 1												
<u> </u>			2 Accident investigation M 1 Yes 2 No							28f. Location (Street and Number or Rural Route Number.				
DIVISION	i git d	ertif	4 ☐ Homicide determi	ned 286 Place	e of Injury - A	at home, farm, str ec <i>ify)</i>	eet, factory, office		28	f. Location (Str. City or Town,	eet and Num State)	ber or Ru	ural Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Direct completely filled in I	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
			(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
		Σ	29b. Signature and title of certifier	11	1		29c. Licens	se number		29	d. Date signe	d (Monti	h, Day, Year)	
	۸,		Jumpa	Hand	m , 1	UD		620			ECEMBI			
	1		30. Name and address of person	1/1/1/18		Item 23a) (Type,	Print)	11/1-	0.00		714			
	Sta	te	31. Date filed (Month, Day, Year)	(ASHI MI 32. F	gistrar's Si	sos Itof gnature	Print) PKINS BAY	VIEW	GRU	LC BA	HIMOR	EM	11) 2/224	
	State Registrar JAN 0 4 2005 32. Rigistrar's Signature													

State of Maryland / Department of Health and Mental Hygiefen [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Jubb Sarah Frances 4:15 A M December 27, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3416 East Pratt Street Baltimore City N/A If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Director 213-01-4853 93 Yrs. Maryland Nov. 3, 1911 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23a or 28a-1 show other traumatic event, the Mudical Examiner must be notified at Baltimore City Maryland 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 3416 East Pratt Street United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after of Hygiene. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: White 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) . 1 and 2 should be filed wi Health and Mental Hygien tem 27 is marked other th Own Home <u> Housewife</u> 2 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Marion Horney Francis Brune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a important: If item 27 is eny injury or othar trau 2005. 3416 East Pratt Street Baltimore, Maryland 21224 Mr. Gerald Jubb, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Sacred Ht. of Jesus Cem. 12/31/2004 Dundalk, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Su O Fui MC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner A Sequentially list conditions, it day, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physicien and for use as the burial-transit The law requires that the death certificate be executed Diom that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year 4☐Pregnant at time of death Month Day 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been sig seen Mr 1 ☐ Yes 2 ☐ V6 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? OIRO 24a. Was an autopsy certificate 1 Yes 1 🗆 Yes Division of Vital the Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 1 ☐ Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 esidence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Dear 28c. Injury at Work? 28d. escribe how injury occurred Certification; 28b. Time of After Natural Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o 24 hours aft e Funerai Di tetely filled in 29a. Certifier 1) certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) Jinen un 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 4 2005 Registrar

Amend item#8, perFH, 6840, 2/1/05 TT State of Maryland / Department of Health and Mental Hygiens 0.01. 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DECEMBER 29, 2004 RICHARD LIONEL JAMESSON JR. 13:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHESTERTOWN QUEEN ANNE'S 312 FAIRVIEW DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1914 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1914 | 9. Birthplace (State or Foreign (Month, Day, Year) | 1914 | 1915 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1916 | 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 579-56-7510 60 Director Yrs Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov wast be notified at 1 ☐ Yes 2 ☐ No Director ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 408 PHIRNE ROAD Itams 23a 21061 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Madical Exercitives Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Tes 2 No Specify: 3 ☐ Widowed 4 M Divorced WHITE natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 PRINTING PRESSMAN PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental t RICHARD LIONEL JAMESSON, SR. MARY CATHERINE COURTNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l MR. MICHAEL JAMESSON / SON 200 SOUTH CAROLINA AVENUE, PASADENA, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o once. ⊠ Burial 2 □ Cremation 3 □ Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS JAN 4,2005 CROWNSVILLE, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, of complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final manoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. | 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of prior to condeath? autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 0 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this home 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death, investigation 1 Yes 2 No 2 Accident Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a a Funaral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-30-04 20051786 cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete BICLS Signature 20 tertown, mo Speer 31. Date filed (Month, Day, Year) State Registrar JAN 0 4 2005

			1 - Stata Ragistrar		artment of Health and M rtificate of Death	lental Hygier Reg. 1	004 41	191
	Physici		1. Decedent's Name (First, Middle, Last) Clarence H.	Johnson			Your Voor	me of Death
	/Medio		4a. Facility Name (If not institution, give street Muntapheny Cour	0	4b. City, Town, or Location of Death		1c. County of Death Montalme	nı
	Funeral Director		5. Social Security Number 6. Sex 238 - 28 - 2777 10 M 2	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea D9 - D8 - 1	9. Birthplace (St. Country)	tate or Foreign
	aryland show	L	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, Town or Lo				de City Limits
	with the Maryland e or 28a-f show	Directo	10e. Street and Number		SVIIIE 10f. Zip Code 21723	10g. (Ditizen of What Country?	763 272110
36	or items 23	by Funeral Director	11. Marital Status 12. W. Ar 1 Never Married 2 Married 1 1 1 1 1 1 1	as Decedent Ever in U.S. 13. med Forces? Stress 2 □ No res, Give	Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American India Black, White, etc. Specify: BLACK	
15-0036	"natur	Completed b	15. Decedent's Education (Specify only highest grade com	pleted) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		Kind of Business/Industry TATE OF M	lD
d 2121	should be filed within ad Mental Hygiene. marked other than "imatic event, In a Max	Be Com	Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	bllege (1-4or 5+)	Driver 18. Mother's Name	e (First, Middle, Maid	pt. of Socials en Sumame)	services
Maryland	s 1 and 2 should be filled I Heelth and Mentai Hyg Itam 27 is markad othe othar treumatic event,	To B	Clarence Johnson 19a. Informant's Name/Relationship (Type, Pr	rint) 19b. Mailir	Ellama		Or Town, State, Zip Code)	
	is 1 and 2 of Heelth a item 27 is other treu		Willye B. Johnson 20a. Method of Disposition	20b. Place of Dispo	H Millers Mill Road	1	le MD 2172 Location - City or Town, Sta	
Baltimore,	Page nent o ent: If ury or		1 [Surial 2 ☐ Cremation 3 ☐ Remov. '4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ure of Fureral Service License	Cresta			imotsville,	MD
Ba	permit. Departr Importe any inj		Naugh (A	5	2. Name and Address of Facility aughen C. Ereene F 15 Pautimore Nat	Tonal Pike	Baltimore MD	212251 ximate
	Physician /Medical		23a. Part1. Exter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	se on each line.	. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	or respiratory arrest,	Interva	al Between and Death
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):	oth, ore		yea Ja	<i>y</i>
.O. Box 68	requires that the death certifics een signed by the attending pt houid be detached for use as t	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
<u>α</u>	luires that n signed b ild be deta	by	Part II. Other significant conditions contribute	ing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	ouse contribute to the cause	e of death?
I Records,	The law ete has b page 2 sl	Completed	cepsis			24a. Was an autopsy performed?	24b. Were autopsy find prior to completion death?	of cause of
Vital	ician: certific rector,	o Be (25. Was case referred to medical examiner? 1 Yes 2 No Hospita	al: 1 X Inpatient 2 □ ER/Outpatier	Cther	(Check only one)	C [] (24) (2) (3)	
o.	Jing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year) 2 □ ER/Outpatier 28b. Time o Injury		me 5 Hesidence 28d. Describe how in		
Division	5 \$ \$ 5 ⊆	Certification:	4 Homicide	e. Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, Sta		Number,
	the Hospitei hin 24 hourse the Funerai I mpletely filled	edicai	(Check only 2 Medical Examiner: C	To the best of my knowledge, deat on the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. nd place, and due to the cau	use(s)
	To the Comp	N	29b. Signature and title of certifier	What	29c. License number 045391	29d. D	Date signed (Month, Day, Ye	00 4
	10		30. Name and asdress of person who complete	ed cause of death (Item 33a) (Type,	Print) CHUCK	NWOS CIM	J MD 20850	
1	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	مناله			

Amend item#5, perFh, C839, 1710/05 TT State of Maryland / Department of Health and Mental Hygie (1) Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** DECEMBER 29. ANNA GRACE KRIDENOFF 2004 2:10 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TIMONIUM STELLA MARIS BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/9/1923 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. **Director** MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "neturel", or Items 23a or 28e-f shov the Medical Express must be notified at 1 ☐ Yes 2 ☐ No BALTIMORE PARKVILLE Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8509 OAK ROAD 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene CLOTHING MANUFACTURING 4TH GRADE SEAMSTRESS filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental 1 and 2 should be ANTONIO LEMME MARIA MORLESANO 19a. Informant's Name/Relationship (Type, Print)
HUSBAND 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)
GARDENS OF FAITH CEM. HALTIMORE, MO 21234 JESSE C. KRIDENOFF, JR. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of Ho Importent: If iter 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö 1/3/2005 PARKVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. 11. Enter the disease, or complication that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arlains 1)ijease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2. No Month Day 4☐Pregnant at time of death 5 Other (specify) the o detached 9 Unknown 9 Unknown signed by I ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has page 5 autopsy performed certificate 1 Tes 1 ☐ Yes 2 ☐ No 2/2 No Division of Vital 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 € Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 🗀 Accident Director: the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 0 To the Hospitel within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 ALMOOD 201-109 Back River Neck Rd 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

A.M.

Kridenoff

			State of Maryland / Department of Health and Me 1 - State Registrer State of Maryland / Department of Health and Me Certificate of Death	ental Hygiei Reg.	としては	41793
	Physici /Medic		John Malshy Klausing	2. Date of Death Month Lecember	Day 2004	3. Time of Death
}	Examir	ier	4a. Facility Name (It not institution, give street and number) Battimore Rehabilitation Extended Care Center BALTIMORE		4c. County of Deat	
L	Funeral Director		5. Social Security Number 213-03-5891 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) 18 Under 1 Year 18 Under 24 Hrs. 8 Hours 18 Min. 9 Usual Residence of Decedent	3. Date of Birth (Month, Day, Ye. 11-9-191	ar) 9. Birtl Co 5 M2	nplace (State or Foreign untry) ARYLAND
	Maryland I-f show	tor	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2X No
	h with the 23a or 28a	ai Director	10e. Street and Number 10f. Zip Code 21206	10g.	Citizen of What Co	•
980	be filed within 72 hours after death with the Maryland nat Hyglene. d other then "natural", or Itams 23a or 28a-f show avant, Ita Medical Erior is are treast by redified at	by Funerai	3 Widowed 4 Divorced Year or Dates WWII	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: WI	
21215-0036	d within 72 h giene. sr than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR	7	. Kind of Business/I	ndustry
Maryland	2 should be filed withir and Mental Hygiene. is markad othar than aumatic avant, I'm Ma	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (F		len Sumame) UBY)	
	12 = Z		19a. Informant's Name/Relationship (Type, Print) DOROTHY KLAUSING/ WIFE 19b. Mailing Address (Street and Number or Rural F 400 DANVILLE ROAD BALTI	Route Number, Cit		ip Code)
Baltimore,	permit. Pages 1 ar Department of Hea Important: If itam any injury or other once.		20a. Method of Disposition 1 □ XBurial 2 □ Cremation 3 □ Removal from State 1 □ Cremation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) CARDENS OF FAITH CEM 1-4-20		Location - City or T	
Balt	permit. Departr Importa			ACH/ROSED ROSEDAL	ALE FUNER	RAL HOME 237
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Coverney Artery Disease.	respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	<u>_</u>	resulting in death) Due to (or as a consequence of): Congestive theart failure B. Due to (or as a consequence of): Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed are been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
Box 687	eath certificate attending phy: I for use as the	0			23d. Date of deli	very
o.	t the deatl by the atte	Physician/M	in the past 12 months? 1		Month	Day Year
rds, P.	w requires that been signed should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes		the cause of death? bably 4 Dunknown
al Records,	: The law re cate has bei , page 2 sho	Completed		24a. Was an autopsy performed 1 Yes 2 1 1	death?	opsy findings available ompletion of cause of
Vital	Physician: Th this certificate ral director, pag	o Be	examiner?		€ □Other (Spec	:4.1
	fter	-	Tanipation Electrodipation Close	d. Describe how in	- ' '	ily)
Division	ital or Atturs after de ra Directo	Certification:		City or Town, Sta		
	To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	at the time, date a	and place, and due	to the cause(s)
)	To To Con	2		Dece	oate signed (Month)	Day, Year)
(P		30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) George E. Wicks III M.D., 3900 Loch Raven Boul.	evard,	Battimor	e, MD. 21218
	Sta Registr		or. Date field (World), Day, Teary			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) **Physician** Joan K. Kronenberg /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Stella Maris @ Mercy Hospital 5. Social Security Number **Funeral** 6. Sex Days Hours 1 M 2 F 152-50-1859 51 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "netural", or Items 23a or 28e-f show the Medical Examiner must be netified at Maryland Anne Arundel Hanover Director 10e. Street and Number 10f. Zip Code 1435 Fairbanks Drive 21076 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 ☐ Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced

Year 3:17 PM December 31 2004 4c. County of Death Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 12/31/1953 NJ 10d. Inside City Limits 1 ☐ Yes 270 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 12 Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kronenberg Rhoda Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Moller / Husband 1435 Fairbanks Drive Hanover MD 21076 20b. Place of Disposition (Name of cemgtery, crematory or other place)
Bayview Crematory Jan. 5, 2005 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final U6061~> Drain disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE:

Physician /Medical Examiner

physician and the burial-transit

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page 2 certificate

director,

After

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Director: Af

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Be Completed

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Certification:

Medical

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

of Vital

Division

or Attanding Physician:

Ith and Mental Hygiene.

27 is markad othar then it traumatic avant, the Mental Market in the Mental

permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Is rr any injury or othar traum once.

2 should be fi and Mental H

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23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 Ø No

5 Pending

investigation 6 Could not be

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

and manner stated

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an 21-No

Reg. No.

3. Time of Death

2. Date of Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 No 1 Yes

26. Place of Death (Check only one)

Other:	4 Nursing H	lome	5 Residence	6 Other (Specify)	hospice
Injury at			Describe how inj		

28c. Injur Wor 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

29c. License number

Baltimore

2005

State Registrar

51 Riseberg 32. Fi gistrar's Signature

30. Name and address of person what ompleted cause of death (Item 23a) (Type, Print)

Paul

			1 - For State Registrer	State of Ma	aryland /	Depa <i>Cer</i>	irtment of F tificate of	Health and Me <i>Death</i>		gierz 00 L	41795
	Physici	an	Decedent's Name (First, Middle, L. Ruth Emma	Kowalczy	r le				2. Date of Dea Month cember		3. Time of Death
	/Medie Examir		4a. Facility Name (If not institution, gi				4b. City, Town, o	or Location of Death	cember	29, 2004 4c. County of Dea	10:20 P M
	Funeral Director			Hospice, Ir Sex 7. Ag 1□M 2\FF	ac je (In yrs. last b	irthday) Yrs.	Baltim If Under 1 Year Months Days		8. Date of Birth (Month, Day	N/A 2 Year) 9. Bi 18,1925 Nev	thplace (State or Foreign ountry) V Hampshire
			Usual Residence of Decedent						ildal y	10,1725 NC	
	h the Maryland ir 28a-f show	ŏ	MD Baltime	ro.	Balt:						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number	71.6	Dait.	LIIIOI	10f. Zip Code			10g. Citizen of What C	
	23e or	ai D	5936 Cecil Aver	ue			2120	07	τ	Jnited Stat	es
1036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Items 23e or 28e-f show ant, the Madical Examiner must be notified	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 H If Yes, Give A Year or Dates:			Vas Decedent of H Yes, specify Cuba	Hispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- lican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
Maryland 21215-0036	Jwithin 72 ho piene. r than "natur fre Medicel I	mpietec	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	5+)	(Give life. L	ent's Usual Occup kind of work done OO NOT use retired Person	oation during most of working d)	g	MD Industr	ies For
d 2	Hygie other	ဇင္	8th 17. Father's Name (First, Middle, Las	")	100	1168	rerson	18. Mother's Name	(First, Middle,	The Blind Maiden Sumame)	
/lan	2 should be filed and Mental Hygi Is marked other reumatic event,	To B	Alphonse Talb	ot				Annie 1	Merchan	it	
Mary	12 sho h and 7 Is ma treuma		19a. Informant's Name/Relationship							r, City or Town, State,	
je, 4	ges 1 and 2 should t of Health and Men If item 27 Is marke or other treumatic		Mrs. JoAnn Calla 20a. Method of Disposition		20b, Place	of Dispos	sition (Name of	Da		Maryland	
O E	Pages nent of ant: If it		1 🖾 Šurial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci	Removal from State (fy)			Forest \		6/05 O	wings Mill	s, MD.21117
Balti	permit. Page Department of Important: If any injury or once		21. Signature of Funeral Service Lice	nsee		8	Name and Addre	ess of Facility Lor:	ing Bye Randall	rs Funeral stown,Mary	DirectorsIn land 21133
18			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lii	the death. Do	not ente	r the mode of dyin	ng, such as cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. (0	nce	K	Ot/	MAG			3mo
	Examiner		(Due to (or as	a consequence	of):					
3/6	P #	iner	Sequentially list conditions, it any learning immediate cause. Enter Underlying	Due to (or as	a consuquence	of):					
Do.	xecute and II-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence	of):					
7 (98760	ficate be executed physician and is the burial-transit	edicai E		d		·					
₩.	= - 4	Medi	IF FEMALE:								
.0. Bo	requires that the death certi een signed by the attending nould be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)	<u> </u>		23d. Date of de Month	livery Day Year
Val	w requires that been signed t should be det	by	Part II. Other significant conditions	contributing to death b	ut not resulting	in the un	derlying cause giv	en in Part I.		pacco use contribute to es 2 □ No 3 □ Pr	
K 01	The taw ate has b page 2 si	Completed							24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of
Vita Vita	Physician: Th this certificate ral director, pag	Be c	25. Was case referred medical examiner?	Hospital:			all post Oth	26. Place of Death (160,000
Ma	ding Phys h. After this funeral di	n: To	27. Manne of Death	28a. Date of Injui		Time of	3□ DOA 28c. Injun	4 Nursing Home		once 6 Do ther (Spe ow injury occurred	city especie
4 Visior	Attending I r death. ector: After by the funer	Certification:	1	n	y rear	Injury		Yes 2 No			
# ivi	l or Atten after deat Director; I in by the	artifi	3 Suicide 6 Could not determined	28e. Place of Inju- building, etc	ury - At home, f c. <i>(Specify)</i>	arm, stre	et, lactory, office	28	If. Location (St. City or Town	reet and Number or Ro , State)	ural Route Number,
Ru	Hospite 4 hours Funerel ely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of miner: On the basis of and manner sta	examination at	e, death	occurred at the tin estigation, in my o	ne, date and place, an pinion, death occurred	d due to the ca at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1	/	سددا	29c. License	e number	2	9d. Date signed (Monti	h, Day, JYear)
	\mathcal{D}		JIMW N/	(Klyne)	N		1/	2012		12/3/	104
1	.4		30. Name and address of person who	completed cause of d	eath (Item 23a)	Type, F	rint)	RN BA	Husi	ra Mill	2/010
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	461	would !	114 211		1114	4/2/8
	Registr	ar .	JAN 0 4 2	2005 Steen	e st	190					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a, perFH G839 1/4/05 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 29, 2004 **Physician** 11:10 P M KAHN STANLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE N/A 123 W. CONWAY STREET | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 06/03/1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 87 MD Director 214-14-2000 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland neat of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or Items 23a or 28a-f show try or other them. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1y Yes 2 □ No Be Completed by Funeral Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 123 W. CONWAY STREET 21201 U.S.A. 12. Was Decedent Ever in U.S. Anged Forces? 1 ⚠ Yes 2 ☐ No NAV If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. NAVY 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 OWNER HEARING AID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DAVID 2 KAHN ANNA DeLEON 19a Informant's Nama Relationship (Type, Prigt) Son DENNIS KAHN / SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1955 CASTLETON ROAD DARLINGTON, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. BALTIMORE HEBREW 01/03/2005 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 1000 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2003 disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1 Yes Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 24 hours after death Pruneral Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) BELANA REMO. man GAMBOO 61 Registrar's Signature State Registrar

			For State Registrar		State o	of Marylan	nd / Dep <i>Ce</i>	artmen	t of ⊢ e of i	lealth Death	and M	lental Hy	gierje	004	41797
			Decedent's Name	e (First, Middle	, Last)						- T	2. Date of De	ath		3. Time of Death
	Physici: /Medic		Steven		D.	т	ewis					Month Decemb	er 28	Year 2004	
	Examin		4a. Fecility Name (I	f not institution			A VY L	4b. City,	Town, o	r Location	of Death			County of De	
			Howard Co	ounty G	eneral Ho	spital		Colum	bia				HOW	ard	
	Funeral		5. Social Security N	umber	6. Sex	7. Age (In yrs.	last birthday) If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Vear	9. B	irthplace (State or Foreign Country)
	Director		215-44-73	379	1 XX M 2□ F	60	Yrs.	Worth	Days	riours	IVIII I.	Sept. 2			linois
	pu 🔏		Usual Residence of 10a. State	Decedent 10b. County		10c Cit	ty, Town or L	coation				Dopos			104 Inside Circle Service
	aryla shov	_		ŕ	_	TOC. CIT	ty, Town or L	ocation.							10d. Inside City Limits 1 ☐ Yes XXNo
	Ba-f	ecto	MD	Howai	rd	Cc	lumb								
	with the	Dir	10e. Street and Nun					10f. Zip	Code				10g. Citiz	en of What C	Country?
	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28a-f show the Modical Examinations by multified at	Funeral Director		aulkne	er Ridge				044					USA	
	er de Item	nue	11. Marital Status	APTE.	Amed Fo	edent Ever in U	i.S. 13.	Was Deced	tent of H cify Cuba	lispanic Or an, Mexicai	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.))- 1.	 Hace - Am Black, Wh 	nerican Indian, ite, etc.
36	rs aft	by F	1 Never Marri		led IXINES If Yes, Gi Year or D	^{2□No} 196	7	1 🗆 Yes	XX 0	Specify:			5	Specify: V	Mhite
Ş	ture	edi		15. Decedent		Dates: 1969	1	edent's Usua	d Occur	ation			16b Kin	d of Busines	e/Industry
5	in 72	Completed		ify only highes	it grade completed)		(Give	b kind of wo.	k done d	durina mos	st of worki	ing	TOD. IXIII	d of Edsiries	amdustry
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þ	filed Hyg other	e C	17. Father's Name ((First, Middle,			COME	Jucer				(First, Middle			Toyeu
<u>a</u>	ld be ental ked c	To Be	Frank Le	ewis						Pos	a Cr	contr	•		
Z.	S should be filed withir and Mental Hygiene. is marked other than aumatic event, Italy.	-	19a. Informant's Na		nip (Type, Print)		19b. Maili	ing Address	(Street			A Route Numb		Town, State,	Zip Code)
Baltimore, Maryland 21215-0036			Claudia	Lewis	s/ Wife										bia, MD 2104
ē,	s 1 and 3 Health Item 27 other tra		20a. Method of Disp	position		20b. F	Place of Disponentery, cre	osition (Nan	ne of		KIUg	Date	20c. Loc	ation - City o	r Town, State
Ω	Pages nent of I int: If its iry or o		1 ☐ Burial 💥 `4 ☐ Donation		3 Removal from	State					: דוכו ומכ	6,2005	T. 2111	ral	MD
量	permit. Pag Department Important: I eny injury o		21. Signature of Fu			рац		2. Name an							
Ba	permit. Departr Importa eny inje		> M/1	ins 1	V	//					MIT	zke Fur			
			23a. Part1. Enter th	he disease, or	comp ications that of	caused the deat						oad, Co.		a, MD	21045 Approximate
_ [shock, or heal Immediate Cause (rt failure. List	only one cause on e	each line.			•	9,					Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)		a	e Coron		TIQEON	e 						
	Examiner				_	or as a consequence rtension									
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687	ficate p phy is the	edic			0.										
Box	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent	comant		tcome of pregna							23	3d. Date of de	livery
/ M	atter for u	ciar	in the past 12	months?		oirth 2 ☐ Feta nant at time of d		□Ectopic pr □ Other (sp		'			20	Month .	Day Year
P.O.	the d y the	ysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9□ Unkn				,,						
٣.	es that igned b be deta		Part II. Other signifi	icant conditio	ns contributing to d	eath but not res	ulting in the u	underlying ca	ause give	en in Part I		23e. Did t	obacco us	e contribute i	to the cause of death?
p	uires isigr id be	q p	Arthrit	is								10	Yes 2 🗆	No 3□F	robably 4 Donknown
Ö	w require been si	lete										24a. Was	20	24b Moro o	uutassu findinga availabla
Division of Vital Records,	sicien: The law s certificate has t lirector, page 2 s	Completed by	Obesity									autor	osy ormed?	prior to death?	completion of cause of
ā	n: Ti ficate nr, pa		06 146									1 ☐ Yes		1 ☐ Ye	
Ξ	sicie certi recto	o Be	25. Was case referrexaminer?	/	Hospital:		/		A Cthe			(Check only o			
of	Phys r this ral di	\vdash	1 Yes 2 2				ER/Outpatie		^	4 🗀 14	_	ne 5 🗌 Resid			ecify)
- Lo	ding h. Afte fune	tlon	1 Natural	5 Pending		of Injury th, Day Year)	Injury	M	Bc. Injury Work	k? Yes 2 □		200. 20001120 1	now injury	occurred	
3	deat deat ctor: , the	Certification:	2 Accident 3 Suicide	6 ☐ Could r	ot be	of Injury - At he	ome farm et			103 2	-	28f Location (Street and	Number or E	lural Route Number,
≥	after Dire	ertii	4 Homicide	determ	build	ing, etc. (Specif	y)	reet, ractory	, onice			City or Tov		TVUTTIDET OF T	and Hobie Number,
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a, Certifier	1 Certifyin	g Physician: To the	a best of my kno	whelme door	th occurred	at the time	no data an	d place a	and due to the	021100/-1 -	nd manner -	s stated
	Hos 24 ho Fun stely	edical		2 Medical	Examiner: On the b	asis of examina ner stated.	ition and/or in	vestigation,	in my of	pinion, dea	ith occurre	ed at the time,	date and p	lace, and du	e to the cause(s)
	ithin o the	Me	29b. Signature and	title of certifier		nor otatod.		290	License	e number			29d. Date	signed (Mon	th, Day, Year)
	F ≥ F 8		> ~	1						-674	8			-	2004
	10		20 No.		she see state t		- 00-1		000				10	- 68	- T
	10		30. Name and addre		who completed caus	se of death (Item	loval (eap	CT	- (=	farm	BA	20	2104) (-
	Sta	to	31. Date filed (Mont	th Day Year	22.5	logistroe's Signs	NA LIFE				051.5				-
	Registr			IANIA	4 2009	e.	H	break.							

Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Frances Mae Ladner December 30 2004 8:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1618 Cypress Street Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🔀 F 219 05 1088 Director 84 May 10, 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 √ Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1618 Cypress Street 21226 or Itams 23a U.S. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) fraumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11th Own Home f Health and Mental Hygi Itam 27 Is marked othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Hopkins Mildred Costin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ethel Lockner / Daughter 1618 Cypress Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It eny injury or o rtment of 1 XBurial 2 Cremation 3 Removal from State Glen Haven Men. Park 1/4/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 234. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final Physician LZHEIMEIZ DEMENTIA Parc resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to income the control of the conditions of the con Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last burial-1 Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 100 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has rector, page 2 2 No 1 ☐ Yes Attending Physician: funeral director, 25. Was case referred to medical examiner?
1
Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After Natural 5 Pending investigation after death. 1 □ Yes 2 □ No 2 Accident in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide filled within 24 hours a To the Funaral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29b. Signature and title of certifier DOZSIGI TOWERS GLEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16 klar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

JAN 0 4 2005

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	rtificate of L			2004	41800
1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day								ith	3. Time of Death	
	/Medi			[. Loude	en			Decembe	er 28 2004	4 2:00 PM
	Examir	ner	4a. Facility Name (If not institution, g. 14201 Quail Creek		. 102	4b. City, Town, or Sparks	Location of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6.		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	y Year) 9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent		56 Yrs.			April Bay	3, 1948 Pe	ennsylvania
	arylanc show	_	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the Ma	ecto	MD Baltimor	`e	Sparks	144 = 2 1				1 ☐ Yes 2 🔀 No
	h with	ai Dir	14201 Quail Creek	Way Apt.	102	10f. Zip Code 21152		l l	10g. Citizen of What C JSA	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumetic event, If a Medical Execution in the realities.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
5-0	72 hou		15. Decedent's E (Specify only highest g	Education	16a. Dece	dent's Usual Occupa	ition	ina	16b. Kind of Business	
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	D+) _	kind of work done d DO NOT use retired) ance Adju		ing	Insuranc	
	filed Il Hygie other	Be Co	17. Father's Name (First, Middle, Las	t)	111301			e (First, Middle, i	Maiden Surname)	.e
Maryland	should be ind Mental ind marked c	ToE	John William	Tobias					llovich	
Mar	d 2 sh th and th and 17 is m treum		19a. Informant's Name/Relationship Mrs. Lisa Louden			Stonewoo			r, City or Town, State,	Zip Code)
Jre,	ss 1 and of Health item 27 other to		20a. Method of Disposition		20b. Place of Dispo			1	20c. Location - City or	Town, State
Baltimore,	Pages ment of l ent: If it		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Spec		Grandview		1-5-	05	Annville,	Pa.
Ball	permit. Page Department of Importent: If any injury of		21. Signature of Funeral Service Lice	insee		. Name and Address UCK TOWSO		l Home	1050 Yor	k Road MD 21204
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cof shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a.Artenio	ne.	er the mode of dying	1			Approximate Interval Between Onset and Death
20,	ficate be executed g physician and as the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence of):					
68760,	ficate g bhysicas the k	edicai		d						
P.O. Box	The law requires that the death certifinate has been signed by the attending roage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	þ	Part II, Other significant conditions	contributing to death b	ut not resulting in the ur	derlying cause giver	n in Part I.		pacco use contribute to	
ပ္ပ	law r as be 2 sh	Completed						24a. Was ar autops perform 1 Yes 2	24b. Were au prior to death?	utopsy findings available completion of cause of
al Re			Or Western State and State							2 No
Vital Records,		o Be	25. Was case referred to medical examiner?	Hospital:	nt 2 □ ER/Outpatien	Other	26. Place of Death	(Check only one		
		To Be	examiner? Yes 2 \(\text{No} \) 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Da)	ry 28b. Time of	3 □ DOA Other	4 ☐ Nursing Ho	ne 5 X Reside	nce 6 Other (Spe	
	ding Physicien: h. After this certifica funeral director, p	To Be	examiner? Types 2 No 27. Manner of Death 17 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	28b. Time of Injury	28c, Injury a Work? M 1 76	4 □ Nursing Ho	n (Check only one me 5 X Reside 28d. Scribe ho	nce 6 Other (Spen	Sify)
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director.	Medical Certification; To Be	examiner? Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigated 3 Suicide 4 Homicide 6 Could not to determined 29a. Certifier (Check only one) 29b. Signerture and titler of certifier 30. Name and address of person who all the filed (Month, Day, Year)	28a. Date of Injuries 28a. Date of Injuries 28e. Place of Injuries 2	28b. Time of Injury 27 At home, farm, stree. (Specify) of my knowledge, death examination and/or invited.	Other 28c. Injury a Work? M 1 Ye et, factory, office occurred at the time estigation, in my opin 29c. License	4 Nursing Ho	me 5 Reside 28d. scribe ho 28f. Location (Str City or Town and due to the ca ad at the time, da	reet and Number or Rt., State) susse(s) and manner as the and place, and due and place, and due and place and glace.	stated. to the cause(s) Day, Year)

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 pM Year LUMPKIN Month **Physician GERTRUDE** Μ. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner EDENWALD** NURSING CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M XXF 213-03-4268 90 Vrs 02-14-1914 MARYLAND Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or itams 23e or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes XX No Completed by Funeral Director MD. BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SOUTHERLY 800 ROAD 21286 U. S. A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X Yoo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**)(**No Specify: WHITE X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRUG COMPANY 12 YEARS ADVERTISING DIRECTOR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Hitent: If itam 27 is marked out Be CARL HOFFMANN HERMINE BECHYNE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9221 CORNFLOWER ROAD, BALTIMORE, MARYLAND, 21236 ALICE M. CUNNINGHAM (NIECE) other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¹XXBurial 2 □ Cremation 3 □ Removal from State
¹ 4 □ Donation 5 □ Other (Specify) ö 01-03-2005 TIMONIUM, MARYLAND permit. Page Department of Importent: If eny injury or once. DULANEY VALLEY M. G. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD H. Kutt RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 □Unknown 1 Tyes 2 100 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2. No certificate 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2/11/0 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 Accident 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation the within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License numbe ni a of person who completed cause of death (Item 23a) (Type, Print) Voverne 31. Date filed (Month, Day, Year) Registrar's Signature JAN 0 4 2005 Registrar

			For State Registrar	State of Ivia	Cei	rtificate of l			2004	41802
	Physicia	an							[™] 29, 2007	3. Time of Death 4 6:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death	DECEMBER	4c. County of De	
	LXdiiiii	CI	NORTH OAKS HEALT	H CENTER		PIKESVIL	.LE		BALTIMOR	E
	Funeral		5. Social Security Number 6. Se	X 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign Country)
Н	Director		219-10-2199 Usual Residence of Decedent	X	93 Yrs.			DEC 19,	1911	MARYLAND
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Ma	ctor	MD BALTIMO)RE	PIKESV	ILLE				1 ☐ Yes 🎗 ☐ No
	23a or 24	Funeral Director	725 MT. WILSON LA	NE		10f. Zip Code	21208	10	g. Citizen of What C USA	Country?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel, or Items 23a or 28e-f show any injury or other treumatic event, I'm Medical Eratic for must be notified at once.	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 [Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of Hif Yes, specify Cuba	ispanic Origin? (Spin, Mexican, Puerto Specify:	ecify Y <i>e</i> s or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	
2-0	72 hc 'netur	eted	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occupa	during most of work	ing 1	6b. Kind of Busines	s/Industry
121	within ane. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	lite	DO NOT use retired HOMEMAKE)		OWN HOME	
9	filed v Hygie other f	ဝ	17. Father's Name (First, Middle, Last)	2		TIONETIME	18. Mother's Name	e (First, Middle, M		
an	uld be fental rked c	To Be	LOUIS		STEIN		ANNA		ISAA	CSON
Maryland	nd 2 shou alth and M 27 is ma r treuma'		19a. Informant's Name/Relationship (7 MRS. NANCY PRAVOR	(DAU.)	19b. Mailir 445	ng Address (Street a	AY DR., #4	AIRoute Number,	City or Town, State, BISCAYNE	Zip Code) , FL 33149
ore,	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I	Domoval from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other plac		Date 20	Oc. Location - City o	r Town, State
Ĕ	Page ment ent: It		'4 □Donation 5 □ Other (Specify,		BETH FL	MEM. PAR	RK 1/2	/05	RANDALLS N & BROS	TOWN MD
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service Licens	attl						., INC. , MD 21208
		h	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each line	the death. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Ga	stric (arcino	ma			Onset and Death
	/Medical Examiner		Tosaking in county	Due to (or as a	consequence of):					
	_	Jer	Sequentially list conditions, if any Isaang to Immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
	cuted nd ransit	Examiner	that initiated events	c						
60,	rificate be executed ng physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequence of):					
68760,	ficate physics the	edica		d						
P.O. Box	Physicien: The law requires that the death certi this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at the 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	s that in ned by e deta	ьу Рһ	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contribute	to the cause of death?
ords	w require been sig should b	ed b	Dementia					1 ☐ Yes	2 □ No 3 □ F	Probably 4 Monknown
Vital Records,	The law recate has be page 2 sho	Completed						24a. Was an autopsy performe	prior to	
/ita	nding Physicien: Th th. : After this certificate s funeral director, pag	Be (25. Was case referred to medical examiner?					(Check only one		
of \	Physi this c	T.	1 Yes 2 No 27. Manner of Death	-	nt 2 ER/Outpatier		4 Nursing Ho		ce 6 □Other (Sp.	ecify)
ono	fter fter	tion	1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 280. 11me of	Worl	rat c? Yes 2 □ No	28d. D <i>e</i> scribe how	injury occurred	
Division of	Attending r death. ector: After by the fune	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	ry - At home, farm, str			28f. Location (Stre City or Town,	et and Number or F	Rural Route Number,
Ö	rs after all Dir	Cert	4 Difficial	building, etc.	. (Эреспу)			Only or rown,	31419)	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best o iner: On the basis of and manner stat	f my knowledge, deatl examination and/or in ed.	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	2 1 ~		29c. License			d. Date signed (Mon	
)	0		> Haren L	jairett,	M.D.	DOC	758676	D	ecember	29,2004
	7		30. Name and address of person who co	ompleted cause of de	M.D. ath (Item 23a) (Type, 25 Mo	Print) Zin Stee	t, suite	200, 12	eisters k	IWN, MID
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 20	32 Registra	r's Signature	ande				21136

State of Maryland / Department of Health and Mental Hygien 41803 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12/14/2004 Yeer Mary Hill Morton 6:35 am M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing Center Sandy Spring MD Mantgamery 5 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 86 412-28-4545 1 ☐ M 2XX Director Yrs 12, 1918 ΊN Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits MD Mantgamery Sandy Spring Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 18131 Slade School Road 20860 USA Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Types 2 No Unk.
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 35 No þ Specify: Specify: white 3 X Widowed 4 ☐ Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I Tenny J. Hill Olive Cooper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Morton / Son 19 Apple Seed Lane Gaithersburg Maryland 20878 Health Hem 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If the any injury or ot ance. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Shipley Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 12/17/04 Bristol, 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. Diwe 1501 Fast Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hewar Rac Immediate Cause (Final disease or condition resulting in death) **Physician** 7 Days /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, HTN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 2 ER/Outpatient 3 DOA this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 Natural Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 Tyes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 1 Continying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) army *D39743* 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) us 1811 Prince Philip Drive dray, up 2083 Chilistop har 31. Date filed (Month, Day, Year) 32. Popistrar's Signature State Registrar

			For State Registrar		State o	of Marylar		artmen rtificat				Mental Hy	gien Reg. N	2001	418	304
ı	∞ Physic		1. Decedent's Name (First	, Middle, Las	t)	- 44						2. Date of De	ath		3. Time	of Death
	/Medi		Evelyn		<u>ـــــ</u>			Marlo	W			Decemb		29, 2004		0 P ^M
	Exami	ner	4a. Facility Name (If not in:		street and nu	mber)				Location of	of Death		4	c. County of Dea	ath	
			Somerford E 5. Social Security Number	Place 6. Se		7 Ann //n	lo as bindonia.	Colu	mbia 1 Year		24 Uro			Howard		
Ĺ	Funeral Director		270-26-1307 Usual Residence of Deced	7	=x □ M XX F	7. Age (In yrs. 84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan. 2	th 9	r) 1920 Ont	rthplace (State Country) CATIO	or Foreign
	yland yow			County		10c, Cit	ty, Town or Lo	ocation							10d. Inside	City Limits
	72 hours after death with the Maryland neture!', or items 23e or 28e-f show dical Examiner must be notified at	tor	MD Ho	ward		El1	icott	City							1 ☐ Ye	s XX No
	ith the or 28	Funeral Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of What C	ountry?	
	ath w	ra	3004 North	Ridge	Road			210	43					USA		
	Items	nue	11. Marital Status	37	Armed Fo		I.S. 13.	Was Deced If Yes, spec	ent of Hi	ispanic Ori n, Mexican	gin? (Sp	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh		
36	rs aft	by F	1 ☐ Never Married 2 3 ☐ Widowed 4 ☐ Di		1 □Yes If Yes, Gir Year or D	XX No ve	1	1 🗆 Yes		Specify:					White	
21215-0036	2 hou	ed		cedent's Ed		4105.	16a, Dece	dent's Usua	d Occup	ation			16b	Kind of Business		
215	d within 72 ho piene. r then "netui ine Madical	plet	(Specify only Elementary/Secondary (highest grad	de completed)	1.4055.\	(Give	kind of wor DO NOT us	rk done c	lurina mos	t of work	ring	100.	Kind of Business	windustry	
21		Completed	Clementary/Secondary (0-12)	College (1-401 5+)	Secr	etary					GOV	vernment.		
pu	be filed ital Hygi id other event, I	Be (17. Father's Name (First, A							18. Mothe	r's Nam	e (First, Middle				
yla	should be nd Mental marked c	P	Ernest W. P	earson	1					Lucia	M.	Crawfo	cd		_	
Maryland	0 0 00 0		19a. Informant's Name/Re	lationship (T	ype, Print)		19b. Mailii	ng Address	(Street a	and Numbe	r or Rur	al Route Numb	er, City	or Town, State,	Zip Code)	
	an Healt m 2		Kathryn Bul 20a. Method of Disposition		ughter	20h E	22 Gr	eat R	oad,	Barr		on, RI		2806		
Baltimore,	ages or of h		1 ☐ Burial 2XXCrem	ation 3 🗆			emetery, crei	natory or o	ther plac	θ)		Date	20c. l	Location - City or	Town, State	
Itim	mit. Pa artmen ortent: injury		' 4 ☐ Donation 5 ☐ O			Bal	timore/v	b shing	tan C	rem Ja	nuary	7 3, 2005	Lau	rel, M		
Ba	permit. Pages 1 Department of H Importent: If ite any injury or ot ones.		Malina.	a /	V - 4	\mathcal{A}_{Λ}	55	. Name an	d Addres	s of Facilit	Witz	ke Fune	eral	Homes,	Inc.	
ì			23a Part1. Enter the dise	ase, or comp	lications that o	aused the deat	h. Do not ent	er the mode	LIIKI e of dvino	NOTTS	Cardiac (or respiratory a	mb1	a, MD 2	1045 Approxima	ato.
A	Physician /Medical		shock, or heart failure Immediate Cause (Final disease or condition resulting in death)	e. List only o	a. FA	rilure	To	THRW							Interval Be Onset and	etween
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Щ		er	Sequentially list conditions if any, leading to immediat	ė		Or as a conseq		TEAR	1	HALL	URC				TOTAL	- TINS
	uted d ansit	Examiner	if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events	~	TR	Louse	> 1888	RECI	ve c	· ***	Dal.				Romanto	- Orner
o o	өхөс an an rial-tr	Exa	resulting in death) Last		U	or as a conseq				(11-11	010				Terrete	, 0,4,0
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9	death certificate be executed e attending physician and of for use as the burial-transit	ĕ	IF FEMALE:													
Вох	eath certific attending p for use as t	Physician/M	23b. Was decedent pregna in the past 12 months	arri.		come of pregna		Ectopic pre	egnancy					23d. Date of de		
0		/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□Pregn 9□Unkno	ant at time of do	eath 5	Other (spe	ecity)					Month	Day	Year
<u> </u>	that the de led by the a detached f	Ph	Part II. Dther significant co	anditions co	ntributing to de	eath but not res	ulting in the u	adarhina as		n in Dort I		220 Did to	abaaaa	use contribute to	the sever of	d450
Vital Records,	law requires that the as been signed by th 2 should be detache	d by	.	101791		(PERTE			iuse give	II III Fai(i.					obably 4	
Sor	v requ	ete					143(014									
Re	9 - 9	Completed										24a. Was autop perfo		24b. Were at prior to death?	topsy findings completion of c	available cause of
la	ician: Th certificate rector, pag	e Co	25. Was case referred to m	nedical								1 Yes	2 2 No		2□ No	
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1 of	g Phys er this eral dir	H.	27. Manner of Death		-	of Injury th, Day Year)	28b. Time of		Bc. Injury Work			28d. Describe h			CITY) ITOSP	ICE.
ior	Attending Ph or death. ector: After th by the funeral	atio		Pending nvestigation	[NOIN	n, Day fear)	Injury	М		? Yes 2	10					
Division	l or Attendater death Director:	Certification;		Could not be determined	28e. Place	of Injury - At ho	ome, farm, stre	eet, factory,	office		1	28f. Location (S City or Tox	Street al	nd Number or Ri	ural Route Nun	nber,
	itel or rs afte ral Dir													,		
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 DCs (Check only 2 Ms	rtifying Phy dical Exami	sician: To the ner: On the ba and mann	asis of examinal	wledge, death tion and/or inv	occurred a restigation,	it the time in my op	e, date and inion, deat	f place, a h occurr	and due to the o	cause(s date an	and manner as d place, and due	stated. to the cause(s	5)
	To t To t	Σ	29b. Signature and title of o	certifier	-			29c.	License	number			29d. Da	ate signed (Monti	h, Day, Year)	
	da		188h					9	14-	268	0	1)ec	-, 30	, 200	4
	17		30. Name and address of p	erson who co		e of death (Item	23a) (Type,	Print)		0	-					-
	,		SABA SHOK	th m	905	1 BAUT	more	NATI	ona	- MICE	,	LUGF	T (in m	2100	12
	Sta Registr	3	31. Date filed (Month, Day,		15 32 A	egistrar's Signa	ture L	who								
1	riegisti		Ortiv		KER	ESSEN SO	1									

			1 - For State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment o	f Health and of Death		gienze () ()	4	41805
1	Physici /Medi		Decedent's Name (First, Middle, Last, Mary Lou	ise Fahy		Masin		2. Date of Dea Month Decemb	er 28,	Year 2004	3. Time of Death 2:45PM M
	Examir	ner	4a. Fecility Name (If not institution, give Collington Nu	rsing Home		M	m, or Location of Dea itchellvi ear If Under 24 Hrs	lle	4c. County Prince	e Geo	
	Funeral Director		5. Social Security Number 6. Second 1076-18-7023-A Cusual Residence of Decedent	יייי ארור	rs. last birthday) 88 Yrs.		lys Hours Min		v, Year)	Coun	place (State or Foreign htry) S Island, NY
	he Maryland 8a-f ehow otiffed at	ector	10a. State 10b. County Maryland Prince G		City, Town or Lo	chellv					0d. Inside City Limits 1 Yes 2 No
	with t	Dir	10e. Street and Number 10450 Lottsford Ro	nad		10f. Zip Cod	0721		10g. Citizen of V	Vhat Coun U.S.	-
9800	be filed within 72 hours after death with the Maryland hal Hygiene. Id do ther then "naturel", or Items 23e or 28e-f ehow event. It e Medical Examiner is ust be multiply at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:			of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race Blace Specify	e - Americ k, White,	an Indian,
1215-(within 72 h iene. then "natu	Completed by	15. Decedent's Edu (Specify only highest grad Elementary(Secondary (0-12) 12th		(Give	dent's Usual Ockind of work of OO NOT use re	one during most of wo tired)		16b. Kind of Bu		
Maryland 21215-0036	hould be filed of Mental Hygie marked other matic event, III	To Be Co	17. Father's Name (First, Middle, Last) Henry T. Fahy		nus.	ic reac	18. Mother's Na	me (First, Middle, se Swett	Music I1 Maiden Sumam		.r y
	ages 1 and 2 should but of Health and Ment: if item 27 is marked or other treumatic e		19a. Informant's Name/Relationship (Ty Helen Masin (Daug		19b. Mailir 2719	So. We	eet and Number or R st 23rd Av	e. Cocon	r, City or Town, ut Grove	State, Zip	Code) 33133
Baltimore,	Pages 1 and the period of the		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	Removal from State	o. Place of Dispo cemetery, crer Lee Crer	natory or other	place) Dec.		20c. Location - Clinton		
Balt	permit. Page Department (Importent: if any injury or		21. Signature of Funeral Service Licens	of moize			dress of Facility Le d Alexandr				on, MD20735
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the done cause on each line. Due to (or all a constant)	andre		dying, such as cardia		rest,	-	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and nd for use as the bunal-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con-							
.O. Box 6	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregna Other (specify			23d. Date Mon	e of deliver	ry Day Year
rds, P.	sign d be	by	Part II. Other significant conditions con	ntributing to death but not	resulting in the ur	nderlying cause	given in Part I.	23e. Did to			e cause of death?
al Records,	The law ate has b page 2 s	Completed	- Hyper Woods	MIR				24a. Was a autops perfor	in 24b. W sy pi med? di 20 No 1	/ere autoprior to comeath?	osy findings available npletion of cause of
ion of Vital	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	atlon: To Be	25. Was case referred to medical examiner 1	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. l	Other	ath (Check only or dome 5 Reside 28d. Describe he	ence 6 ⊡Othe)
Division	el or Attendi s after death. Il Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, offi	се	28f. Location (Si City or Town	treet and Numbe n, State)	r or Rural	Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sicien: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the estigation, in п	e time, date and place by opinion, death occu	a, and due to the carried at the time, d	ause(s) and mar ate and place, a	nner as sta nd due to	ited. the cause(s)
ł	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	_		29c. Lic	1603	2	9d. Date signed	(Month, E	lay, Year)
	10		30. Name and address of person who co William DuBoyo	e 4000 Mit	chellvi1		l #B-216 B	owie, Mar	ryland 2	0716	
	Sta Registr	. 0	31. Date filed (Month, Day, Year)	32. Registrar's Sig	mature Apple	le de					

Mathems Vewsa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Yee Veora Elizabeth Matthews December 6:05 PM /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Balhmore Ballmon HOSpital C 1 14 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** __ 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 € F Director 51 215-82-5864 1953 Maryland 23 June Usual Residence of Decedent the Maryland 10b. County ahow 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic event, the Medical Examiner must be notified at Marylamd N/ABaltimore X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? #103 with 2325 Hollins St. 21223 USA Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpeRlack 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any fujury or other traumatic event, the Machana page. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Never Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel White Earline Matthews 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) 2325 Hollins St. #103 19a. Informant's Name/Relationship (Type, Print) 21223 Darlene Matthews /Sister Baltimore, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 12/29/04 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation _ 5 ☐ Other (Specify) Mt. Zion Cemetery Baltimore, Maryland 21. Signature of Funeral Service Lic Inser 22. Name and Address of Facility Chatman-Harris FuneralHome 5240 Reisterstown Rd Baltimore, Md 21215 Emi 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo cardial One-day terc tron **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner inding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic prøgnancy 2 Fetal death The law requires that the death ίο in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown à ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 No 200No 1 ☐ Yes To the Hospital or Attanding Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3 State Registra

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31. Date filed (Month, Day, Year)

Sinai Hospital 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

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Kes-000

December 23, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MAMIS MARSHALL 10:305M 04 3 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. dounty of Death Harborside Nursing Center Baltimore N/A 5. Social Security Number 214-22-0737 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 28, 9. Birthplace (State or Foreign Country) 4. Virginia **Funeral** 1 □ M 2X F 80 Days 1924 Director Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show N/A Maryland Baltimore Directo Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö #1C 21239 1206 Linworth Ave USA Funeral Pages 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes MNo If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes ¾☐ No Specify: þ 3 □ Widowed 4 □ Divorced "natural", Completed th and Mentat Hygiene.

17 Is marked other than "natur treumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Janitor Holiday Inn 17. Father's Name (First, Middle, Last)
Cleveland Williams 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Bolden 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Claymond Williams/ Brother 5606 Loch Raven Blvd itam 27 I Baltimore, Md 21239 20b. Place of Disposition (Name of cometery, crematory or other place)

Garrison Forest Vet. / Cem. 20a. Method of Disposition permit. Pages 1 Department of H Importent: If its any injury or ot once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Owings Mills, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licens 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STOM ACH Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death P.O. F 5 ☐ Other (specify) 9 Unknown 9 Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown s certificate has be director, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ Ho 1□ Yes 2□No : After this certification funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes ٩ 2 No Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To tha Funarel Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Selena Martin Marv December 31, 2004 10:30 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockda1e Baltimore 3620 Langrehr Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 28) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□M 2 F 215-12-9477 80 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a, State 10b. County or 28a-f show a 23a or 28a-f show 1 Tyes 2 No BAltimore Rockdale Maryland by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21244 United States 3620 Langrehr Road filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ThuNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. or Itama 11. Marital Status other traumatic event, the Mudical Extrainer 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Devoted Mother & Home maker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: If Item 27 is marked other eny injury or other traumait. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Walker Edgar A. Euler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3620 Langrehr Road Rockdale, MD 21244 Mr. George Martin, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olive Cemetery Jan.5, 2005 Randallstown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 8728 Liberty Rd. Randallstown, MD 21133-4784 Dellner M00333 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metast - ~ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medicai Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Year Month ģ Day 4□Pregnant at time of death 5 Other (specify) been signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 2 No 1 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 2 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 2 ER/Outpatieni 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. injury al Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manper of Death Medical Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 📝 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, gistrar's Signature State Registrar

			State of Maryl	and / Depa	artment of Heartificate of De	alth and Menta	•	2004	41809
			Decedent's Name (First, Middle, Last)				te of Death	ay Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death	4	c. County of Deat	
			Laurel Regional Hospital		Laurel				GEORGE'S
	Funeral		15M 20 E	yrs. last birthday) E O Yrs.		Under 24 Hrs. 8. Da lours Min. (M	te of Birth onth, Day, Yea	9. Birt	hplace (State or Foreign untry)
	Director		220-56-6846 Usual Residence of Decedent	53 Yrs.		Mai	rch 26,	195µM	aryland
	MG #	ŀ		. City, Town or Lo	cation				10d. Inside City Limits
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	the ?	ec	10e. Street and Number	College	10f. Zip Code		10g. (Citizen of What Co	untry?
	with Se or		10105 52nd Avenue		20740	0		USA	
	ne 23	era	11 Marital Status 12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N		es or No-	14. Race - Ame	rican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural', or Iteme 23e or 28a-f ehow any injury or other treumatic event, the Medical Examinational De notified at ance.	by Funeral Director	Armed Forces? 1 □ Never Married ②□XMarried 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:		If Yes, specify Cuban, M 1 ☐ Yes 21 <u>7</u> 7 No <i>S</i>		etc.)	Specify: Wh	
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멀	al Hy d oth	Be (17. Father's Name (First, Middle, Last)		18.	. Mother's Name (First		en Sumame)	
<u>la</u>	Ment Ment arked	2	Samuel Joseph Moore			Alma Elmo			
Maryland	2 shc and ls ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				
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ore	of H		1 VRunal 2 Cremation 3 Removal from State	-	matory or other place)			Location - City or	
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Baltimore,	Dependit Dependit Import any in		21. Signature of Funeral Service Licensee		2. Name and Address of 313 Talbott				
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	Physician	ii. I	Immediate Câusé (Final disease or condition resulting in death) Responses	sir al	ory tail	luce			
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Division of Vital Records,	Physician: The rathis certificete ral director, pag	Bec	25. Was case relerred to medical examiner?			5. Place of Death (Che			
†	Ø .s. ₩	To E	1 ☐ Yes 2 【No Hospital: 1 ☐ Inpatient	2 R/Outpatie		4 Nursing Home			cify)
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	To the Hospital or Attending Ph within 24 hours eller death. To the Funerel Director: After th completely filled in by the funeral	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License nu	umber	29d. I	Date signed (Mont	h, Day, Year)
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	.nv						1	- 12/12/	
	10		30. Name and address of person who completed cause of death MEHRU MIASTELL, MB, 6570 K		- NIE C.	CITE SIDO	RIVERI	DALE NI	0, 20723
	Sta	ato	31. Date filed (Month, Day, Year) 32. Registrar's	Signature					J, W. J / J/
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	Dharaisi		Decedent's Name (First, Middle, Last)		11	٨		2. Date of Do		y Year	3. Time of Death
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п	Examin	er	4a. Facility Name (If not institution, give si	reet and number)	afer	4b. City, Town, or	Location of E	Death S	4c	County of Death	n
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi	rth	9. Birth	nplace (State or Foreign untry)
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	vith the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	untry?
	leath v	eral	6615 Bowman Hill D	rive 2. Was Decedent Ever in	U.S. 13. V	Vas Decedent of Hi	21207 spanic Origin	? (Specify Yes or N	0~	U.S.A.	ncan Indian.
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any Injury or other treumatic event, I'm Medical Evantiner must be notified at once.	by Fun	1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	+	Yes, specify Cuba	n, Mexican, P Specity:	? (Specify Yes or No Puerto Rican, etc.)		Black, White	
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ylar	Menta by Menta arked	ToE	Ray Mariner				Rebec	ca Bowers	B		
Maryland	d 2 sh th and 7 is m treum		19a. Informant's Name/Relationship (Type Mr. Ray Mariner /					or Rural Route Numb	-		
	s 1 an f Heali ftem 2 other		20a. Method of Disposition	20b	. Place of Dispo			cive, Gwyn		ocation - City or 1	
altimore,	Page nent o ant: If ury or		1 ☐ Burial 2 🏋 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)				1	ec.30,2004	Ste	vensvil	le, MD
Balt	permit. Departr Importe any Inje		21. Signature of F rat Service License	a may				Singleton S.W., Gle			
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VIII.	Physiclen: Th r this certificete ral director, pag) Be	25. Was case referred to medical examiner? 1 Yes No	ospital: Inpatient 2	C CD/O	Othe	e e	Death (Check only		C [70]	
1 0 f	g Physicar this neral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA 28c. Injury Work	at Nursii	ng Home 5 ☐ Res 28d. Describe			ıry)
sior	Attending Ir death. ector: After by the funer	catlo	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day 1 dar)	пцагу		res 2 □ No				
Division	of or Attences after death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office		28f. Location (City or To	Street ar wn, State	nd Number or Rui 9)	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 12 Certifying Phys	cien: To the best of my ker: On the basis of examinand manner stated.	nowledge, death	occurred at the tim restigation, in my op	e, date and p inion, death	place, and due to the occurred at the time,	cause(s date and	and manner as place, and due	stated. to the cause(s)
	To thi within To the	Me	29b. Signature and title of certifier	Sicil Al	CILIAI	29c. License	number	74	29d. Da	te signed (Month	Day, Year)
7	5		30. Name and address of person who con	- 01	tem 23a) (Type,	Print)	10/	17	DEC	em ot y	VIIWIT
			300 S Hamove		U1)	MD 21.	US				
	Sta Registr		JAN 0 4 2005	32. Registrar's Sig	nature for	W					

Amend item#5, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene 1 1. 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Yeer DEC. Jesse F. Mellott 27, 2004 7:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 336 Magnolia Terrace Essex Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 182 ST 21 8477 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₽M 2□F Yrs. 86 Director Pennsylvania APR. 10, 1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Maude Avenue 21225 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: NAVY 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify white ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Maryland Drydock Rigger 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any lightly or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Be Lloyd Mellott Stella Matilda Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Leonardi - sister-in-law 336 Magnolia Terrace, Essex, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/31/2004 Meadowridge Mem. Park Elkridge, MD `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Dicensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician End stage Chronic Obstructive Pulmonary Disease years /Medical Due to (or as a consequence of): **Examiner** Chronic Renal Failure vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). End stage Cerebral Vascular Accident weeks Due to (or as a consequence of) Physician/Medicai Dysphagia weeks IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Aspiration pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death? Urinary tract infections 24a. Was an autopsy performed? 1 ☐ Yes 2√2 No 1 ☐ Yes 2√☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 21 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide

O. Box 68760. Division of Vital Records. P.

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To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending p been si has certificate this After this funeral c death. Director: d in by the within 24 hours aft To the Funeral Di completely filled in

physician a s the burial-

SS

Registrar

Medicai

31. Date filed (Month, Day, Year) State JAN 0 4 2005

29a. Certifier

29b. Signature and title of certifier

en 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Allen Reilly, MD,

4805 Benson Avenue, Baltimore, MD 21227

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D54749

29d. Date signed (Month, Day, Year)

Dec. 29, 2004

22. Registrar's Signature

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Mary Helen Mosca December 27,2004 03:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore NA Samaritan Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year July 7, 1926 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F 212-22-8091 78 Director Yrs Maryland Usual Residence of Decedent 10a. State 10b Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits raumatic avant, the Medical Examiner must be notified at N/A Director Maryland 1 Ves 2 □ No Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3109 Royston Avenue 21214 USA or Items 23a Funeral Helen Mosca 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No þ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than * Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gust Parthemos Margarita Papapetro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Gus V. Mosca/Son 3109 Royston Avenue Baltimore Maryland 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 12/30/04 injury 4 □ Donation 5 □ Other (Specify) Baltimore Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton

22. Name and Address of Facility
Leonard J. Ruck and Edition

305 Harford Road Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** vation Pheumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be executed Due to (or as a consequence of) physician the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. detached 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Hypertension, Honllation, 1 Yes 2 No director, page 2 should Be Completed 3 ☐ Probably 4 ☐ Unknown , Chronic Obstructive emia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed? Lovonary Disea Artery Disease of Vital 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manyer of Death 28c. Injury at Work? 28b. Time of After Division 1 Natural 5 Pending

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1

State Registrar

hours after death. Inaral Diractor: A

within 24 hours a To the Funaral D

To tha

1

filled in by

Medicai

investigation

6 Could not be determined

amo

JAN 0 4 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Accident

3 Suicide

29a. Certifier

4 | Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

2. Registrar's Signature

М

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

chamion olivier, MD 5601 Look Raven Blvd, Baltimore MD 21239

29c. License number RES 000 28f. Location (Street and Number or Rural Route Number, City or Town, State)

			1- State of Maryland / Dep Registrar Ce	artment of Health and Mental Hy	2007 71010
	<u> </u>		Decedent's Name (First, Middle, Last)	2. Date of De	
	Physic /Medi		Robert J. Moore, Sr.	Decemb	er 31 2004 11:10 PM
Ì	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	F		705 Robin Hood Hill 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Annapolis If Under 1 Year If Under 24 Hrs. 8 Date of Bir	Anne Arundel
	Funeral Director		227-24-1020 1M 2 F 76 Yrs.	Months Days Hours Min. (Month, Da	9. Birthplace (State or Foreign Country) 9. Birthplace (State or Foreign Country) Virginia
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Letter 1	ocation	10d. Inside City Limits
	oath with the Marylan s 23a or 28a-f show ust be natified at	tor	MD Anne Arundel Annapolis		1 ☐ Yes 2 X No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ath wi	ral	705 Robin Hood Hill	21405	USA
980	after de or ftem	by Funeral	1 Never Married 2 X Married 1 XYes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
5-0	hin 72 hours s. an "natural"; Medical Ex	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working	16b. Kind of Business/Industry
121	s within jiene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life.	DO NOT use retired)	
d 2	filed Hygi other ent, I	a l	12 4 Busin 17. Father's Name (First, Middle, Last)	ess Owner 18. Mother's Name (First, Middle,	Construction Maiden Sumame)
Maryland 21215-0036	should be id Mental marked of matic eve	To B	John Henry Moore	Merryll Floyd Dr	
dar	2 she and lam.			ng Address (Street and Number or Rural Route Number	
	1 and Health em 27 ther tr		MaryJane Moore / wife 705 20a. Method of Disposition 20b. Place of Dispos	Robin Hood Hill; Annapoli	
Baltimore,	0 0	П	1 Burial 2 Cremation 3 Removal from State	matory or other place)	20c. Location - City or Town, State
altir	Frank.			Service Corp. 1/5/05 2. Name and Address of Facility	Towson, MD 1050 York Road
ä	Depa Impo any i		R	uck Towson Funeral Home	Towson, MD 21204
300	Pnysician /Medical Examiner		23a. Part 1. Ehter the disease, or complications that caused the death. In not ent shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a	er the mode of dying, such as cardiac or respiratory and	Interval Between
	D #	ner	Sequentially list conditions, it any, leading to intrinsicate cause. Enter Underlying		
	ecuter and trans	Examine	that initiated events		
68760,	tificate be executed g physician and as the burial-transit		Due to (or as a consequence of):		
687	ificate g phys as the	edlcal	d		
.O. Box	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Furnatial Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed by Physiclan/M		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
S, D	ss that gned to se det	by P	Part II, Other significant conditions contributing to death but not resulting to the un	nderlying cause given in Part I. 23e. Did to	obacco use contribute to the cause of death?
ord	require een si nould t	ted	Chronic OBSTRUCTOR JULIUS	MARY DISEASE 104	es 2 □ No 3 □ Probably Unknown
al Records,	i: The law icate has b		ich insulndepedded Bidese	S No///t3S 24a. Was autop perfor	sy prior to completion of cause of
Vital	siciar certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check only of	-
סר	g Phy ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	4 Nursing Home 5 Hesia	ence 6 ☐Other (Specify) ow injury occurred
Sior	ttendin death. ctor: Afi / the fur	atlo	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No	
Division of	l or Att after d Direct I in by I	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. Location (S City or Tow	treet and Number or Rural Route Number, n, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invand manual stated.	occurred at the time, date and place, and due to the crestigation, in my opinion, death occurred at the time, d	ause(s) and manner as stated. late and place, and due to the cause(s)
	To the To the comp	ž	29b. Signature and title of cereter	29c. License number	29d. Date signed (Month, Day, Year)
}	- 1		· Cul Guy	D2535)	1/3/2005
Z	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) ERIC FIShe	RUS
	Sta	ė	31. Date filed (Month, Day, Year) 32. Registrar's Signature	C 311 TOWGON,	MOSIZON
	Registra		JAN 0 4 2005	E)	

				State of Maryland	/ Department of I		Mental Hygien	3004	41814
	. 4		1 - State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Dealli	2. Date of Death		3. Time of Death
	Physicia /Medic		MARY N	14604			December	6, 200	4839 M
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town,	or Location of Death		c. County of Geath	<u>}</u>
	Funeral Director		131-12-3247	M 2DXF 7. Age (In yrs. las	t birthday) If Under 1 Year Months Days		8. Date of Birth Jimonth, Day, Year		pplace (State or Foreign intry) The Carclina
	Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County A	10c. City,	Town or Location	0			10d. Inside City Limits 1
	th with the 23a or 28s	ai Directo	10e. Syeet and Number 342 Bloom	St. #507	10f. Zip Code	217	10g. Ci	itizen of What Cou	intry? A
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Macincal Examiner must be notified at	by Funeral	11. Marital Status 1: 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub	oan, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify:	
21215-0036	within 72 hou lene. then "nature the Macilical E	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wor	16b. H	Kind of Business/li	ndustry
land 21	ld be filed w ental Hygiei ked other ti ic event, Ib	To Be Co	17. Father's Name (First, Middle, Last)	Hararove	rtouser	18. Mother's Nam	ne (First, Middle, Maider	Sumame)	25110
, Maryland	1 and 2 should be Health and Mental em 27 ie marked o ther traumatic ev			e, Print) (ilece)	19b. Mailing Address Stree	lar Di	ive Ba	Ho.Ma	ip Code) 1. 21207
Baltimore,	Ly in a Ba		20a. Method of Disposition **Disposition 3 Re 4 Donation 5 Other (Specify)	Ark	ce of Disposition (Name of netery, crematory or other plants Mem.)	Dark 12/3	20c. L 20/2004 B	alto.	Md.
Ba	permit. Departr Importa any inj		21. Signature of Funeral Service License	L. Kuss	Joseph L 2272 W	RUSS	Funeral Ave Bal	Home	21216
25	Physician		23a. Parti. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death. cause on each line.	Do not enter the mode of dy	ing, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	nce of):				
	be executed sicien and burial-transil	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					
8760,	cate be ex physicien the buria	dical	d.						
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3 Ectopic pregnand	су		23d. Date of deliver Month	very Day Year
rds, P.	tuires that the de n signed by the a uld be detached f	d by Ph	Part II. Other significant conditions conf	ributing to death but not resulting to death but not resulting	ing in the underlying cause g	iven in Part I.	23e. Did tobacco		the cause of death?
Division of Vital Records,		Completed by	Att.	al Fibril	lation.		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to o	copsy findings available ompletion of cause of
Vita	Physicien: r this certifica ral director.	Be	25. Was case referred to medical examiner?	ospital:			th (Check only one)		
on of	ng Phy fter this ineral d	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 Er	8b. Time of Injury Wo	4/CX (Not Sing 1)	ome 5 Residence 28d. Describe how inju		ify)
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Street a. City or Town, Stat	nd Number or Rui e)	ral Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medicai (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowle er: On the basis of examinatio and manner stated.	edge, death occurred at the t in and/or investigation, in my	time, date and place opinion, death occu	, and due to the cause(s rred at the time, date an	s) and manner as id place, and due	stated. to the cause(s)
	To the within : To the comple	Mec	29b. Signature and title of certifier	12 Din Ah	29c. Licen	nse number		ate signed (Month	
	(Dalle AT	ation but	ysicia 6	15364	2 L	2c. 28	3004
	4		30. Name and address of person who con	npleted cause of thath (Item 2	3a) (Type, Print)	on Blud	303 B	Stime	m2(239
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatur					

				1- For State of Maryland / Dep Registrer Ce	artment of Health a		2004	41815
				Decedent's Name (First, Middle, Last)		2. Date of Death	g. No.	3. Time of Death
4		Physic /Medi	cal	RENATA MARIANI	MARINI	DEC.	31 2004	9:10A M
		Exami	ner	4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHRIST CTR.	4b. City, Town, or Location of TOW		4c. County of Dea	ith IMORE
		Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 1 F 7. Age (In yrs. last birthday 79 Yrs.	Months Days Hours	24 Hrs. 8. Date of Birth Min. 07/02/19	9. Bir	thplace (State or Foreign ountry) GERMANY
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	07702713		10d. Inside City Limits
		e Mary 8e-f sh	Director	MD BALTIMORE PHOENIX				1 ☐ Yes 2 No
		death with the Maryland ms 23e or 28e-f show	I Dire	10e. Street and Number 14331 OLD YORK ROAD	10f. Zip Code 21131	10	g. Citizen of What Co	•
		ems 2	Funeral		Was Decedent of Hispanic Orig	gin? (Specify Yes or No-	14. Race - Ame	erican Indian,
	980	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23e or 28e-f show other treumatic event, the Madical Examinat must be notified at	by	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	, Puerto Hican, etc.)	Black, Whit	NHITE
	21215-0036	in 72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	6b. Kind of Business	Industry
	1212	led with lygiene. her the		College (1-40r 5+) INS	TRUCTOR		TEACHING	
	Maryland	12 should be filed within in and Mental Hygiene. 7 Is marked other then "I reumatic event, the Mental In M	To Be	17. Father's Name (First, Middle, Last) WERNER	RANK ERNA	r's Name <i>(First, Middle, M</i> a A		[EDWINSKI
	Mary	d 2 shout h and h			ng Address (Street and Number	r or Rural Route Number, (City or Town, State, 2	
		tem 2		20a. Method of Disposition 20b. Place of Dispo	31 OLD YORK ROA		MD 21131 Oc. Location - City or	Town State
	Baltimore,	Page ment o tent: If		1 🖔 Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify)	CONG. 01		OWINGS MIL	
	Ball	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tree		21. Signature of Euneral Service Licensee 23	2. Name and Address of Facility 200 REISTERSTOW	SOL LEVINSON	N & BROS.,	, INC.
				23a. Part1. Exter the disease, or complications that caused the death. Do not ent shock, or heart willure. List only one cause on each line	er the mode of dying, such as c	cardiac or respiratory arres	t,	Approximate Interval Between
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	stoma			Onset and Death
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14		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
BNA	60,	tificate be executed ig physician and as the burial-transit	al Exa	resulting in death) Last Due to (or as a consequence of):				
B	68760,		edical	d				
	Вох	eath certifi attending for use as	Physician/M		DEctopic pregnancy		23d. Date of deli	very Day Year
3	P.O.	at the de by the tached	hysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Nontr	Day real
MAKIN		The law requires that the death certii ate has been signed by the attending page 2 should be detached for use a	by	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
N	ecor	law req as beer 2 shou	Completed			24a. Was an		topsy findings available ompletion of cause of
-	Division of Vital Records,	ticien: The certificate ha				autopsy performer	d? prior to death? No 1 □ Yes	
	Z.	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	Othor	of Death (Check only one)	. l-s	There
40	n of	tending Physeath.		27. Manner of Déath 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury	. 3 DOX 4 11013	sing Home 5 Residence 28d. Describe how		ity) HOSPICE
31	visio	Attending Physicien: r death. ector: After this certifica by the funeral director, g	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - At home farm stre	M 1 Yes 2 No		at and Number or Rur	a I Route Number
4	٥	pitel or urs afte arel Dire				City or Town, S	State)	
		To the Hospitei or Attend within 24 hours after death To the Funerel Director: A completely filled in by the filed	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or invariant manner stated.	occurred at the time, date and estigation, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner as and place, and due f	stated. to the cause(s)
		To t Withi To t	Σ	29b. Signature and title of certifier Alle, mp	29c. License number	29d.	Date signed (Month,	Day, Year)
216		\n)		30. Name and address of person who completed cause of death (Item 23a) (Type, I	D25205 1 N. Charle	C 0 0		7
60		Sta	0	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 N. Charle	- It. Balq	8. Md e	21205
1	7	Registra		JAN 0 4 2005 Joseph 15 A	medi			

			1 - For State Ragistrar		Maryland		artment o			lental Hy	giene ()	+ L	18	16
	Physic	an	Decedent's Name (First, Middle, La	ast)						2. Date of Dea	Day	Year	3. Time	of Death
	/Medi	cal	Dorothy			Mull				Decembe	r 30, 2	004	6:30	0 PM
1	Exami	ner	4a. Facility Name (If not institution, git Jones Acres Assi		- /		4b. City, Tov		ation of Death		4c. County		uund = T	1
	Funeral				'. Age (In yrs. I	ast birthday)	If Under 1 Y	Arno 'ear lf l	I U Under 24 Hrs.	8. Date of Birt	h		undel	e or Foreign
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	pu *		Usual Residence of Decedent 10a. State 10b. County		10- 01-	, Town or Lo								
	Aaryli f sho	o		Tobaux.	roc. City	, rown or Lo		اء 1 مید				1		City Limits es 2 ☑ No
	28a-	Director	Maryland Anne A	rundel			AY 10f. Zip Co	nold			10-0'''			
	ath with the Marylan 23a or 28a-f show ust be redified at	0	1349 Jones Stati	on Road			Tor. Zip Co		012		10g. Citizen of \	What Coun SA	try?	
	death	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13.)	Was Decedent			ecify Yes or No- Rican, etc.)		e - America	an Indian.	
9	after des or items	/ Fu	1 Never Married 2 Married	Armed Ford 1 Yes 2 If Yes, Give	No ∑ No					Rican, etc.)		k, White, e	etc.	
993	72 hours after death with the Maryland instural, or Items 23a or 28a-f show dical Examiner must be nutified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dat	es:		1 □ Yes 2 □)	(NO SE	oecify:		Specify	. Whi	te	
21215-0036	n 72 nat	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>de completed)</i>		(Give	lent's Usual O kind of work d DO NOT use re	one durino	g most of work	ing	16b. Kind of B	usiness/Ind	ustry	
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br	e filed Il Hygi other /ent, I	BeC	17. Father's Name (First, Middle, Last	')			0001		Mother's Name	e (First, Middle,			- 01	Darto
/lar	should be nd Mental marked o	TOE	James Liber	tini					Mary	Liber	tini			
Maryland	S is a		19a. Informant's Name/Relationship (al Route Numbe		State, Zip	Code)	
	1 and Health em 27 other tr		Michael Mullikin	(son)	1001 51					1, MD 21	122			
altimore,	permit. Pages 1 a Department of Hes Importent: if item any injury or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3		ale		sition (Name of natory or other		Jan.	Oate 03	20c. Location -			
틆	it. Pa irtmen irtent: njury		' 4 ☐ Donation 5 ☐ Other (Special 21. Signature 1 Fun 1 1 rviol ice)		Mead		ge Cem			005	Elkride			
Ba	permit. Departm Departm Importe any inju	1		1309			Name and A		n Road	Stalling , Pasade	Js Funer ena MD	'al Ho	ome, i	P.A.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cau	sed the death.								 Approxima	ate
	Physician	8	Immediate Cause (Final disease or condition	pne cause on eac	fre Let	50		Carea		Cane			Interval Be Onset and	etween
	/Medical		resulting in death)	aC Due to (v	s a conseque	nce of):	00	11 1		Cine	70	-0	Kinn	4
	Examiner	L	Sequentially list conditions,	b	1 all	(e)	Mi	2114	UJ				0469	WS
	ed ssit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):							1	
_6	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or	as a conseque	ence of):						1		
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ŏ	leath certifii attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnan		Ectopic pregna				23d. Date	of deliven	y	
о. В	e dea the att	slci	in the past 12 months? 1 🗆 Yes 2 🛈 No		nt at time of dea		Other (specify				Mor	th C	Day	Year
<u>Ч</u>	The law requires that the death certi te has been signed by the attending bage 2 should be detached for use a	Phy	9 ☐ Unknown Part II. Other significant conditions of			Name to the								
ecords,	signe d be d	Q	Tattii. Other significant conditions of	ontributing to deal	in but not resum	iing in the un	derlying cause	given in F	Part I.		acco use contri			
202	w require been si should t	letec								1 _ Ye			bly 4	Unknown
Re	The tav	Completed								24a. Was a autops perform	y p	fore autops rior to comp eath?	sy findings pletion of c	available cause of
		e Cc	25. Was case referred to medical							1 ☐ Yes 2	No 1	Yes 2	No	
<u> </u>	Attending Physician: r death. ector: After this certific by the funeral director,	OB	examiner? 1 \(\text{Yes} \) 2 \(\text{Yes} \) No	Hospital:	atient 2□El	B/Outpatient	3□ DOA	Other		<i>(Check only on</i> ne 5 ☐ Reside		10	trock	How
1 Of	ding Ph After thi funeral	L:u	27. Manner of Death	28a. Date of I		8b. Time of		njury at Work?		8d. Describe ho	and the second second second	1 1 27.	sije	1 4014
000	endir sath. or: Af he fur	atlo	1 Natural 5 Pending 2 Accident investigation	1	Day 16ai)	Injury		Yes	2 🗆 No					
Division	or Att fler de lirecto n by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At hom, etc. (Specify)	e, farm, stre	et, factory, offi	се	2	8f. Location (Sti City or Town	reet and Numbe . State)	r or Aural F	Route Num	nber,
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	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the basi	s) of my knowl sof examinatio	edge, death on and/or inve	occurred at the estigation, in m	e time, dat 1y opinion,	te and place, a , death occurre	nd due to the ca	use(s) and man ite and place, a	ner as stat	ed. ne cause(s	ŝ)
	Vithin To the Comple	Me	29b. Signature and fittle of certifier		stated.			ense numi			d. Date signed			
•			Mod	sug.	all)	7	1	200	194		12/1	1/00	Í	
			30. Name and address of person who	completed cause of	of death (Nem 2	(3a) (Type, P	rint)	7	10 6	M	0 1	1		4
			MILION GO	titya	0/10	111	Mack	boch	Per/	Drive.	He B	4418	, 49	21061
	Stat Registra		31. Date filed (Month, Day, Year) JAN 0 4 200		istrar's Signatur	ге	d .			7				

			For State Registrar	State of M	aryland			of Health of Death			giene Reg. No.	004	41817	
Phy	ysicia	an l	1. Decedent's Name (First, Middle, La	,						Date of Dea Month	Day		3. Time of Death	
	/ledic		ZENNA MAE	NELSON						Jecems.		28 2004	325 A M	
Ex	amin	er	4a. Facility Name (If not institution, giv UPPER CHESAPER	KE MEDI	CAL	CENT	R		VIR		H	County of Death		
Fun Dire			245-34-3059	Sex 7. Ag 1□M 2X F	ge (In yrs. I	ast birthday) 7 Yrs.	If Under 1 Months [Year If Unde Days Hours		8. Date of Birtl (Month, Day NOV • 11	y, Year)	9. Birthp Coun 927 North	lace (State or Foreign etry) n Carolina	
and	**		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation					11	Od. Inside City Limits	
Many -f she	led	to	Maryland Harford		F	allsto	n						1 ☐ Yes 2X No	
ith the Marylan or 28e-f show	to a	Director	10e. Street and Number				10f. Zip C	ode			10g. Citi	zen of What Coun	try?	
1th wil	d d	alD	2026 Falls Grove	Way			210	47			USA			
Dattillicie, Ivial ytatio 4 14 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or items 23e or 28e-f show	amparm	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces' 1 ☐ Yes 2 If Yes, Give	?	If	Vas Deceder Yes, specify ☐ Yes ※	nt of Hispanic On Cuban, Mexica	an, Puerto F	cify Yes or No- lican, etc.)		14. Race - Americ Black, White, of Specify:		
hour.	EX.	q pa	Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:	1	16a Deced	ent's Usual (Occupation			16h Kir	Whi nd of Business/Ind		
in 72 n na	de dis	Completed	(Specify only highest gra	ade completed)	F.\	(Give I	kind of work OO NOT use	done durina mo	st of workin	g	100. 1(1	nd of basinessmit	watty	
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should b	etic e	0	Cicero Edmun		pard				issa	(unm)		Watson		
12 sh n and	Lenu		19a. Informant's Name/Relationship (r Town, State, Zip	•	
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artme	Injury		4 ☐ Donation 5 ☐ Other (Special 21. Signal upon funeral Service Aice		Bro	xxview 22		tery Address of Facil	12/31			ing Sun, eral Home	Maryland	
permit. Departi	eny ir	1	Sille Millo	March At	MALL				LIC				yland 2101	
Pnysic /Med	ical		23a. Part 1. Efter the disease, or com shock, oh beart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hip &	d the death	. Do not ente	or the mode		s cardiac or	respiratory and			Approximate Interval Between Onset and Death	
icate be executed physician and	4	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Que to (or as										
UNISION OF VICE INCIDENCE OF SOLVED TO THE HOSPITED BOAT OF COUNTY, TO THE HOSPITED OF Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and	ched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♠ No 9 ☐ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 KNo								23d. Date of delivery Month Day Year		
w requires that	ild be deta	þ	Part II. Other significant conditions BRONCH'S EC		but not resu	, , , , , , , , , , , , , , , , , , , ,						pacco use contribute to the cause of death?		
		olete	OSTEOPOROS	21						24a. Was			osy findings available	
The la	page	Completed	DIABETES		us					autop: perfor 1 Yes	med? 25 No	death?	npletion of cause of 2 No	
VII.d Ilclen: certific	rector,	Be	25. Was case referred to medical examiner?	Hospital:				Other		(Check only or				
2 E E	ıral di	- Lo	1 Yes 2 No 27. Manner of Death	28a. Date of Initial	urv	ER/Outpatient 28b. Time of		. Injury at Work?	100000000000000000000000000000000000000	ie 5 ∐ Resid 8d. Describe h		Other (Specify occurred)	
Attending at death.	e fune	tior	1 Natural 5 Pending 2 Accident investigation	on 12/22/0		UNK	М	Work? 1 ☐ Yes 2 🛛	No	FALL	AT	HOME		
Atte	by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of In		me, farm, stre	et, factory, o	office	2	8f. Location (S City or Tow	treet and	d Number or Rural		
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To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has	completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) 1□ Certifying Pl 2★ Medical Exe	hysician: To the best miner: On the basis of and manners	t of my know of examinat tated.	wledge, death tion and/or inv	occurred at estigation, in	the time, date a my opinion, de	ath occurre	nd due to the d d at the time, d	ause(s)	place, and due to	ated. 2 10 4-7	
To the Within	сош	M	29b. Signature and title of certifier	Con soll 1	THIE		De	icense number	206		Done	e signed (Month, L	Day, Year)	
20			30. Name and address of person who	completed cause of	death (Item	23a) (Type, I	Print) Ho)	ARINA	ALLE	D-1 -	Nr.	12 2		
) 	Sta egistr		31. Date filed (Month, Day, Year)	3. Hegist	trar's Signat	ture	الأنظم	יער	MA	21V-1	0 "	W 212		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Veal **Physician** Miriam Milestone Ochsman December 30, 2004 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10401 Grosvenor Place #420 Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2**X**) F Director 579-42-5864 82 01/25/1922 Missouri Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10a State 10d Inside City Limits 7 is marked other than "neturel", or Items 23a or 28e-f show treumatic event, the Medical Event ar must be notified at 1 ☐ Yes 2 ▼ No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 10401 Grosvenor Place #420 20852 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene.

Is marked other than "neturel", or Itel 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ð 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Herman Benjamin Dora Krupsaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is r Joanne Ochsman, Daughter 5135 King Charles Way, Bethesda, Maryland 20814 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or permit. Page Department of Important: If any injury or once. `4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 01/05/2005 Brentwood, Maryland 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 4 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Non-Hodgkins' Lymphoma 3 years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 1□ Yes 2X No To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 V Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this id in by the funeral d 28b. Time of 27. Manner of Death Date of Injury (Month, Day Year) 28c. 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License number D21531 January 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Peter Pushkas, MD, 11510 Old Georgetown Road, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) State JAN 0 4 2005 Registrar

Amend item#/, perfyr, G839, 1/5/05 TT
State of Maryland / Department of Health and Mental Hygiens 0.1. Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Shane Officer 5:00 PM 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AGNES BALTIMORE HEALTH CARE S7. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 12,1962 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1**⊠**M 2□F Months Days Hours 064-56-8360 Brooklyn, NY Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. and it if it is a start of team 23a or 28a-f show and it if it is a 23a or 28a-f show and it if it is a start of other traumatic event. It is the distriction and the notified at any or other traumatic event. MD Anne Anundel Pasadena 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 224 Mulberry Ridge Ct ISA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes. Give 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education Student Advisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bostvice officer UNK. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6423 Union Ct. Glen Burnie MD 21061 Charlotte Officer / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Forest Green Cemetery Morganville, NY 1 ☐ Burial 2 ☐ Cremation 3 Amemoval from State 1/4/05 permit. Page Department of Important: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Meral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave. Baltimore Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMO THORAX NATIS resulting in death) /Medical Due to (or as a consequence of): Examiner CARINI PNEUMONIA MEUMOCYSTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an has page 2 autopsy performed? 1 Yes 2010 or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After 5 Pending investigation 1 Natural 1 □ Yes 2 □ No death. 2 Accident in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 M Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide illed within 24 hours a 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P-18619 DEC, 27, 2004 DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ISMA1LA AGNES HEALTHCARE, 900 S. CATON AVE., BALTIMORE ST. JIBRIN 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 4 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 4 41820 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Pervez 04:18 AM Melanie De 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Ade (In vis Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/11/1977 Funeral 7. Age (In yrs. last birthday)
27 Yrs. Birthplace (State or Foreign Country) 214-17-9593 Months Days Hours 1 □ M 2000€ Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f ehow other traumatic event, the Medical Exertiner must be notified at N/A MD Baltimore City 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1243 William Street 21230 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes Z Mo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Itam 27 is marked othar than "natural", or Itel 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: þ White Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Horton Sandra Wingate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Horton / Father 1813 Parkside Drive, Pasadena MD 21122 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If Ita 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Holy Cross Cem. 30, 2004 Baltimore MD December 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee Victor Doda $\mathbb{Z}_{0,1}($ 1501 E. Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Endocarditis /Medical Due to (or as a consequence of): Examiner Ulmonasy HEMORINAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Toxic Shock syndrome 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? Preumonia certificate has 1 ☐ Yes 2∏ No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attanding within 24 hours after death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P18601 12 26 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green Baltimore, MD 2120 Alexandra Pratt 32. Regittrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland /	Certificate of Death	Reg. No.	+ 41821
	Dhuaisia		Decedent's Name (First, Middle, Last)	2	Date of Deeth Month Day Year	3. Time of Death
	Physicia /Medic		LOUISE POULSON		ECEMBER 30 200	4 3:50 AM
	Examin	_	4a Fecility Name (If not institution, give street and number)	4b. City, Town, or Loca		
			Lorien Nursing Home	00.00	i'a Howa	
	Funeral Director		5. Social Security Number 5. Sex 1 M 2 D F 7. Age (In yrs. last bit of the strength of the	Months Days Hours Min.		rthplace (State or Foreign ountry)
	puel wo	ŀ		vn or Location		10d. Inside City Limits
	Mary 1-f sh	ğ	MARYLAND HOWARD	COLUMBIA		1 ☐ Yes 2 ☒No
	h the 28 28 28 28 28 28 28 28 28 28 28 28 28	Director	10e. Steet end Number	10f. Zip Code	10g. Citizen of Whet C	country?
	th wi	ai	6334 CEDAR LANE	2104	14 45	SA
	terms	Funeral	11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric 	fy Yes or No- can, etc.) 14. Race - Am Black, Wh	
21215-0020	72 hours after death with the Marylend "neturel", or items 23a or 28a-f show solles! Examiner must be notified at	ک	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛱 No Specify:	Specify:	BLACK
15-	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 	16b. Kind of Business	s/Industry
12	within ene.	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	JURSE/PRIVATE DU	1 1	TAI
	other other	ပ္	17. Fether's Neme (First, Middle, Last)		First, Middle, Maiden Surname)	1116
Maryland	A # 75 6	To Be	MATTHEW Co	ATES LOUIS	E REV	NOLDS
ary	2 should and Man Is marke aumatic			b. Mailing Address (Street and Number or Rural F		
	D = 6 5		CAROL POULSON-BUSCH DAUGHTED 7	261 EDEN BROOK D	Date 20c. Location City o	D. 21046
ore	of Haai of Haai I Item 2			of Disposition (Name of ery, crematory or other place)	Date 20c. Location City o	r Town, State
Ë	nit. Pag entment ortant: it injury o		4 Donation 5 Other (Specify) ARB	UTUS CEMETERY 01-		
Baltimore,	permit. Pag Depertment Important: I any injury o		21. Sig 1 of Funer I Service Lice s	22. Name and Address of Feolity BK	000100.	ERAL HOME
	ALIENS IN	Н	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.			MD 2/2// Approximate
	Physician					Interval Between Onset and Death
1	/Medical		Immediate Cause (Final disease or condition Alzheim	er's Dementi	a	5 years
	Examiner		resulting in death)	consequence of):		
Н	P #5	Iner	a h			
	icate be executed physician and s the bunal-transit	Examiner	Sequentially list conditions,	consequence of):		
60,	be ex		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			1
68760,	ntificate be executed ng physician and es the bunal-transil	edical		consequence of):		
	n certifica ending pl use es t	ΣI	d			
Box	at at	Physician/	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	23b. Did tobecco use contribut	to the cause of deeth?
0	res that tha de signed by the a l be detached i	hys				Probably 4 Unknown
۳.	s that med to e det	ఠ	Congestive heart Fai	lure	7.3.140 12.110	, ,
īġ	v require been sig should b	8	Congestive heart Fai Chronic obstructive pul	nonary disease	24a. Was an autopsy performed?	Were autopsy findings available prior to
သ	law requias been	pie	Chrome obstinuite fue		,	completion of cause of death?
ď	The la ata ha page	Completed			1⊟Yee 2XNo	1 ☐ Yes 2 No
/ita	entifical	8	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
£	hysle his o	၉	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/O		5 Residence 6 Other (Spe	ecify)
n o	aling Ph h. After th funerel	<u></u>	1 Natural 5 ☐ Pending (Month, Day Year)	Injury Work?	d. Describe how injury occurred	
isic	Attending ir death. octor: After by the fune	Cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury. At home, for	M 1 ☐ Yes 2 ☐ No	f. Location (Street and Number or F	Rural Route Number
Division of Vital Records,	il or Attendir attar death. I Director: Af d in by tha fu	Certification:	4 Homicide determined building, etc. (Specify)	arm, street, factory, office	City or Town, State)	larar Floate Number,
			29a. Certifier 1X Certifying Physicien: To the best of my knowledge	e, death occurred at the time, date end place, and	d due to the ceuse(s) and manner a	is stated.
	n 24 h	edicai	(Check only one) Medical Examiner: On the basis of examination are and manner stated.			
_	To the Ho within 24 I To the Fu completal	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
			· KM MI	? D 56531	Dec 31	,2004
1	2		30. Name end address of person who completed cause of death (Item 23e)	(Type, Print)		6
1	(/)		Harry Li, 10780 HiCK	D56531 (Type, Print) Cory Ridge Rd, (olumbia, MD	21044
1	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registra	1	JAN 0 4 2005	books		

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	aryland	-	artment of tificate o				Reg. No.	004	41822
	Physicia		1. Decedent's Name (First, Middle, PAUL	DARICER	_					2. Date of De	ath Day	2004	3. Time of Death
3	/Medic Examin		4a. Facility Name (If not institution, BON SELOVR		TAL		46. City, Town					unty of Death	<u> </u>
	Funeral Director		5. Social Security Number 217-26-7977 Usual Residence of Decedent	6. Sex 7. Ag 1 XM 2 ☐ F	je (In yrs. las 73	st birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Bird (Month, Da 12/01/1	y, Year)	Coun	ace (State or Foreign try) Carolina
Maryland	Maryland	tor	10a. State 10b. County Maryland			Town or Lo					-	10	0d. Inside City Limits 1 Yes 2 No
	with the	Directo	10e. Street and Number				10f. Zip Code					of What Coun	try?
•	72 hours after death with the Maryland natural', or itams 23a or 28a-f show disal Examinat must be notified at	Funeral	3326 Mondawmin 11. Marital Status 1 □ Never Married 2 ☑ Marrie	12. Was Decedent Armed Forces?	?	1 1	Vas Decedent of Yes, specify Co	f Hispanic Or uban, Mexica		ecify Yes or No Rican, etc.)		Race - America Black, White, e	
215-0036	72 hours a natural', o lical Exar	ρ	3 Widowed 4 Divorced 15. Decedent' (Specify only highest	Year or Dates: s Education	1953	3 16a. Deced	1 Yes 2 N	upation		ina		ecify: Bla	
7	filed within Hygiene. other than "other than"	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Line	DO NOT use reti	red)				lation	
Maryland	should be fi ind Mental H i marked ot imatic avar	To Be	Paul Parker Sr. 19a. Informant's Name/Relationsh	·		19b Mailin	ng Address (Stre	Eva	Ruth	First, Middle, Spurge	on		Code)
	1 and 2 Health a am 27 is ther tra		Dolores L. Parke		20b. Pla	3326 ce of Dispo	Mondawn sition (Name of natory or other p	in Ave	≥., B		e, Ma		21216
Baltimore,	t. Page tment c rtant: ff njury or		1 🕅 Burial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service)	ecity)		rison	Forest Name and Add	Ceme.					, Maryland H, P.A.
ñ	permi Depar impo any ir gnce.		23a. Part1. Enter the disease, or	C. 7	4 01							, Maryl	and 21215 Approximate
1	Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	EUMo	MA						~1.5	Interval Between Onset and Death
	Examiner	iner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		nce of):	TRUCTI SI SORD		16113	Norte (7180	ASE	
8760,	cate be executed physician and the burial-transit	dical Examin	that initiated events resulting in death) Last	Due to (or as		nce of):	ne		٤				
O. Box 6	death certifi e attending d for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal d	leath 3	Ectopic pregnal				23d.	. Date of deliver Month	ry Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant condition DETYDATE HYPEN LIE	ns contributing to death t	out not result	ing in the u	nderlying cause	given in Part	l.		obacco use o		e cause of death?
Vital Records,	The lay	Completed	Hypen LIA	IDEPUA	<u> </u>					24a. Was autor perfo 1 \(\text{Yes} \)		prior to con death?	psy findings available apletion of cause of
VIta	sician: Th certificate irector, pag	o Be (25. Was case referred to medical examiner?	Hospital:	205	D/O-+)thora		Check only o		101	,
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely illed in by the funeral director.		1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da	Zimpatient 2 Envolupatient 3 Book 4 Industrig notice 3 Environment (Special)
Divis	spital or Attending Pours after death. naral Diractor: After tilled in by the funera	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of in	jury - At hom tc. (Specify)	ne, farm, str	eet, factory, offic	ee		28f. Location (3 City or Tov		umber or Rurai	Route Number,
	To tha Hospi within 24 hour To tha Funar completely fill	edical	(Check only 2 Medical E	p Physician: To the best xaminer: On the basis of and manner s	of examination tated.	on and/or in	vestigation, in m	y opinion, de	ath occurr	ed at the time,	date and pla	ice, and due to	the cause(s)
)	with	Σ	29b. Signature and title of certifie	ALTEN	MING		29c. Lice	nse number	48		DEC Date si	igned (Month, L	Zeo Y
	2		30. Name and address of person v	who completed cause of ANSIMO 32. Regist	death (Item 2	23а) (Туре, Чр ў	Print)	LPHI	v 50	NEEY,	BALT	JAMME,	21.517
*	Sta Registi		31. Date filed (Month, Day, Year)	N 0 4 2005	rar's Signatu	re	· Asse						

Amend item#10a-1, per FH, G839, 1/25/05 The State of Maryland / Department of Health and Mental Hygiene 0 0 4 1- For Registrar AMEND ITEM 18&19a PERINF G 840 rt Eichard Of Death Reg. No. Month 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** ecember 27,2004 Jayne Louise Pattee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cecil 694 Budds Landing Road Cecilton 8. Date of Birth (Month, Day, Year 4/29/1922 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 ☐ M 252 F Ohio 82 279-18-5971 Director Usual Residence of Decedent FL_{MD} 10c. City. Town or Location 10d. Inside City Limits 10h Count 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic evant. It a Medical Examinst must be mailled at 1**X**Yes 2 ₹No -Cecil Cecilton FORT MYERS Director 10g. Citizen of What Country? 10f. Zip Code 33905 10363 MUSKEGON AVE. 694 Budds Landing 21913 U.S.A. Road death 1 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amød Forces? 1 ☐ Yes 2 No If Yes, Give 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White If Yes, Give Year or Dates: 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nayn jujury or other traumatic event. If a Muanane. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Blowdwin Karl Byus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (*Type, Print*)
Susan Schumaker Daughter PO Box 488 694 Budds Landing Road Cecilton, MD. 219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Balto./Wash. Crem. 1/2/05 Laurel, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licen 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cancer Lung Physician disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed the burial-tran Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No jo 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, ρ pe 1 Nes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Other (Special) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 📉 No 0 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence this a feel mes 2 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Director: Af 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 29a. Certifier Excertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) en Che sapeake Hospice, Elkton Sugons 1263 w Registrar's Signature 31. Date filed (Month State 2005 4 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician EILEEN WINIFRED RINI 31, 2004 4c. County of Deeth /Medical DECEMBER 7:45 A.M. 4b. City, Town, or Locetion of Deeth 4a Fecility Name (If not institution, give street end number) Examiner 603 HILLEN ROAD TOWSON If Under 24 Hrs. BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1 □ M 2 □ F Director 485-10-3148 86 6/2/1918 COLORADO Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Directo ir than "natural", or itams 23s or 28s-f the Medical Examiner must be notifie TOWSON MD BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 603 HILLEN ROAD Funerai 21286 USA Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE <u>۾</u> 3 Ty Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) and Mental Hygiene. PAYROLL MORAN CO. 12TH GRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HENRY CALLAHAN SARAH O'CONNOR 19a, Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health a : If itam 27 is or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place)

CONTROL TOWSON, ML

Date VICTOR RINI SON 21286 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State Department 4 ☐ Donation 5 ☐ Other (Specify) CRESTLAWN MEM. GAR. 1/4/2005 MARRIOTTSVILLE, MD 22. Name and Address of Facility 21. Signaturé of Funeral Service Licenses THE JOHNSON FUNERAL HOME, P.A. TOWSON, MD 8521 LOCH RAVEN BLVD. 21286 Mu 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Brain Mass Examiner Due to (or as a consequence of). Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as e consequence of) attending pl 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☐ Unknown Dementia þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificata has b lirector, paga 2 sl f TYes 2 LINO 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 3□ DOA Certification: To this Director: After third in by the funeral 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Dil completaly fillad in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier D56705 Enhelle January 3rd, 2005 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Bayview Circle, Baltimore MD 21224 Rachelle GAJADHAR, 5505 Hopkins 32. Resistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** /Medical 4b. City, Town, or Location of Death County of Death me (If not institution, give street and number, **Examiner** Year If Under HOSPIC TIMORE Date of Birth (Month, Day, 5-27 Age (In yrs. last pirthday) Security Number Birthplace (State or Foreign Country) **Funeral** 213-28-8546 Months Days Hours Min 1 M 2 Z F Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Extrairer roust be notified at 1 ☐ Yes 2 No Completed by Funeral Director HUTMORE ARKUI 10f. Zip Code 10g. Citizen of What Country? 123 IPTON d 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. be filed within 72 hours after catel Hygiene. 1 ☐ Yes 2 ☐ No 1 Never Married Married Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) emaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental marked 2 oman ma Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or T Health tem 27 -aaug Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation √5 ☐ Other (Specify) TIMONIUM MD 2009 S YOU -CREW ATION OTR e or comply List only on Approximate Interval Between Onset and Death Part1. Enter the disease shock, or heart failure. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisase or it, jury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, 1 Tes 2 No 3 Probably 4 Vunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2**X** No 1 🗌 Yes Vital To the Hospitel or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 ☐ Yes 2 XNo 4 ☐ Nursing Home 5 ☐ Residence 6 ★Other (Specify) HOSPICE Medicai Certification; To 1 Inpatient 2 ER/Outpatient 3□ DOA of in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Division 1 X Natural 5 Pending death. 2 Accident investigation **Director**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 - Homicide pelli 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

DECEMBER

RODER

2300 DULANEY VALLEY RD.

32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	Certificate of	Death	Reg. No	UUU	41826
	Physician /Medical	Decedent's Name (First, Middle, Lest SHARON LEE	REDCLIFFE			Date of Death Month ECEMBER	31 2004	3. Time of Death 6:54 am
	Examiner	4e Fecility Name (If not institution, give FRANKLIN SQUARE		4	4b. City, Town, or Locati ROSEDALE	ion of Death 40	c. County of Deeth BALTIMO	
	Funeral Director	5. Social Security Number 6. Se	x 7. Age (In yrs. last	birthdey) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth Month, Day, Year 5-20-1950	9. Birth	place (State or Foreign intry)
	show ed at	Usuel Residence of Decedent 10a. Stete 10b. County MD BAI	10c. City, T	own or Locetion MIDDI	LE RIVER			10d. Inside City Limits 1 ☐ Yes 2X No
	with the Ma te or 28s-1 s Les notified I Director	10e. Street end Number 808 A. WILSON POI	NT ROAD	10f. Zip Code	1220	10g. C	itizen of Whet Cou	
936	72 hours effer deeth with the Maryland natural; or items 23s or 28s-f show dical Examinar must be notified at effect by Funeral Director		12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates:		lispanic Origin? (Specify an, Mexican, Puerto Rica	/ Yes or No- an, etc.)	14. Race - Ameri Black, White	ican Indian,
Maryland 21215-0036	d within glene.	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12) 10		6e. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired DISABLED	ation during most of working d)		Kind of Business/Ir	ndustry
pur	tal Hyginal Hy	17. Father's Neme (First, Middle, Last)			18. Mother's Name (Fi		· ·	
aryla	d 2 should be filed the and Mental Hyg 7 is marked othe traumatic event, Traumatic event,	WILLIAM SPITT 19a. Informent's Name/Relationship (T)		9b. Mailing Address (Street	EVELYN end Number or Rurel R	(MARSH) oute Number, City		p Code)
, Ma	end 2 :	JESSE REDCLIFFE/H		308 A WILSON E			RIVER, MC	
Baltimore,	permit. Peges 1 en Depertment of Heali Important: if fem 2 any Injury or other phos.	20a. Method of Disposition R☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State PARK	of Disposition (Name of stery, cremetory or other place WOOD CEMETER)	Z 1 –4:	-05 BAI	ocation - City or T	MD
Ball	permit. Pe Depertmen important: any injury pnce.	21. Signeture of Funeral Service Lidens	0 e		ss of Fecility CVACI ACO AVENUE	H/ROSEDAI ROSEDALE		L HOME 237
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the death. In cause on each line.	o not enler the mode of dyir	ng, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
4	Physician /Medical Examiner	Immediate Ceuse (Final diseese or condition resulting in death)	MYDCARDIA		MON			IMMED
	iner art		CORONARY	a consequence of): VASCULAR	DISEA	SE	l i	YEARS
90,	ficate be assecuted a physician and st the buriel-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):				11
x 68760,		that initiated events resulting in death) Last	Due to (or as	e consequence of): ENAL FA	ILVRE		1	cl
. Box	death certifi e attending ed for use es	Part II. Other significant conditions con	ntributing to death but not resulting	g in the underlying cause giv	ven in Part I.	23b. Did tobaće	o use contribute 1	to the cause of death?
, P.O.	requires that the death certli een signed by the attending hould be detached for use e hould by Physician/Mi	HYPERUPID				1 Yes	2□ No 3□ Pro	obably 4 🗆 Unknown
Division of Vital Records,	requir been s should	HYPERTENS	1010			24a. Was an auto performed?	av	Vere autopsy findings veilable prior to ompletion of cause f deeth?
I Re	The law ate has pege 2					1 ☐ Yes 2	21 [™] No 1	☐ Yes 2년 No
Vita	cartific rector	25. Was case referred to medical examiner?	lospitel: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3□ DOA Oth	26. Plece of Death (Coner: 4□ Nursing Home		6 □Other /See	(6v)
ion of	Par Par Po	27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation		b. Time of 28c. Injury Wor		. Describe how inju		·"
Divis	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director. After completely filled in by the funera Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f.	Location (Street a City or Town, Stee	und Number or Rui te)	al Route Number,
	he Hospitu in 24 hours he Funera pletely fills	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exami	sician: To the best of my knowled ner: On the basis of exemination and menner stated.	dge, deeth occurred at the tir end/or investigation, in my o	me, date end place, and pinion, death occurred e	due to the cause(set the time, date an	s) and manner es	stated. to the cause(s)
	To the comple	29b. Signature and title of certifier	the stated.	29c. Licens	e number	29d. D	ate signed (Month)	Day, Year)
,	Н	30. Name end address of person who co	ompleted cause of death (Item 23	e) (Type, Print)	LTIMMER V	40 217	7.36	
	State Registrar	31. Date filed (Month, Dey, Year) JAN 0 4 21	32. Registrar's Signature	e South		, ,		

OHIGINAL

DHMH 16 Rev 6/95

			For State Registrar	State of Marylar	id / Depa <i>Cei</i>	artment of He rtificate of D	ealth and M Death		2004 I. No.	41827
П	Physici		1. Decedent's Name (First, Middle, La					Date of Death Month	Day Year	3. Time of Death
	/Medic			n Ragar, Sr.		1		December	30, 2004	
	Examin	er	4a. Facility Name (If not institution, giv	· ·		4b. City, Town, or			4c. County of Dea	
			102 Seneca Avenu 5. Social Security Number 6. S		last birthday)		de Grace	8. Date of Birth	Harfo 9. Bir	thplace (State or Foreign
	Funeral Director			∑ M 2□F	2 Yrs.	Months Days	Hours Min.	(Month, Day, Y Sept. 19	ear) Co	ountry) Iarvland
	P .		Usual Residence of Decedent					Dept. 19	7 2550	
	arylar show	_	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M 28a-f	Director	Maryland Harford	Н	avre d	e Grace		100	Chinag of 18th at C	
	with t		100. Street and Number	•		10f. Zip Code 21078		109	J. Citizen of What Co USA	ountry ?
	ns 23	Funerai	102 Seneca Avenu	12. Was Decedent Ever in U	.S. 13.	Was Decedent of His	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian,
ထ	or itar		1 Never Married 2 Married	Armed Forces? 1 □XYes 2 □ No If Yes, Give		If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, Whit	te, etc.
ĕ	ours a	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ X No	Specify:		Specify: Wh	ite
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or flams 23a or 28a-f show avant, the Medical Expiditor out by notified at	Completed	15. Decedent's E (Specify only highest gra		(Give	dent's Usual Occupa kind of work done d	uring most of work	ing 16	b. Kind of Business	/Industry
7	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) todian			Public Ed	ucation
р 5	Hygie Hygie ther	e Co	17. Father's Name (First, Middle, Last)	Cus	COULAII	18. Mother's Name	e (First, Middle, Ma		ucacion
au	lid be lental ked c	To B	Garland Henr	y Ragar			Mary	Eileen	Hugh	es
Maryland	should and Men a marke numatic		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Number, C	City or Town, State,	Zip Code)
_	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 ia marked other than "natural", or itams 23a or 28a-1 show other traumatic avant, the Medical Excitition was the multiled at		Dora Lee Ragar -							land 21078
altimore,	of He of He If itan		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crei	osition (Name of matory or other place		Date 20	c. Location - City or	Town, State
Ē	permit. Pages Department of I Important: If it any injury or o		4 Donation 5 Other (Special	y) Du		issionary		/01/05	Darlingto	n, Maryland
Bai	Depar Mpor Iny in		21. Si vialure of Funeral Service Lice	nsee ()		2. Name and Address	. 1		uneral Ho	
	402 % 0		233 Bart Edge the disease or com	unlications that caused the deal						land 21009
Ш			23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	WILL		A	, such as cardiac i	or respiratory arrest	L _g	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	aDue to (or as a consec	MON	19				3 DAYS
Н	Examiner			Due to (of as a consec		10pg				4 MONTHS
		Je	Sequentially list conditions, if any Isaams to immediate cause. Enter Underlying	Due to (or as a cons	uence of):	July				77001011
	cate be executed physician and the burial-transit	Examiner	that initiated events	c.						
90,	oe execian a	i Ex	resulting in death) Last	Due to (or as a consec	quence of):					
8760,		dicai		d						
×	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregn.	ancy				23d. Date of de	livery
Вох	The law requires that the death certifi tle has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnancy Other (specify)			Month	Day Year
о. О.	res that the de signed by the a be detached f	hys	9 Unknown	9□ Unknown						
_	gned geded	by P	Part II. Other significant conditions	contributing to death but not res	sulting in the u	inderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	o the cause of death?
ord	w require		COPD					1 Yes	2 No 3 P	robably 4 Unknown
Records,	e law r has be ge 2 sh	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
_		Con						performe 1 ☐ Yes 22	d? death?	2 No
Vita	ding Physician: Th. n. After this certilicate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	C	(Check only one)		
Division of	Phys rthis ral di	: To	1 ☐ Yes 2 ØNo 27. Manne of Death	28a. Date of Injury	ER/Outpatier 28b. Time o	IL SEL DON	4 Nursing no	me 5 Residence 28d. Describe how	injury occurred	icity)
on	nding f th. : After s funera	tlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	? 'es 2 □ No			
N S	l or Attano after death Diractor: in by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, sti	reet, factory, office		28f. Location (Stree City or Town,	et and Number or Ri	ural Route Number,
ā	tal or A rs after al Dirac ed in by	Certification;	4 - Hornida	building, etc. (Speci				Ony Grown,		
	To the Hospital or Attanding Physician: within 24 hours after death. To tha Funeral Diractor: After this certifical completely filled in by the funeral director,	edicai ((Charteness Election)	nysician: To the best of my knominer: On the basis of examina	A' 41 '-		the state of the second)
	thin 2-	Medi	one) 29b. Signature and till of certified	and manner stated.		29c Linenen	number	204	Date signed (Mont	th Day Year
	To To		255. Signature discussed of Certifier			DU	2022	250	Dero al	30 70010
/	110		30. Name and address of person who	completed cause of death (Ite.	n 23a) (Tyne	Print)	, ,		- CENTOEUP	20,0009
	D7 ,		Du MATI WA	HS441 9 407	5. Unin	m AVE H	grop do	GRACE 1	NOZO:	18
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's agn	ature	L 1 1	2	1		
No.	Registr	ar	JAN	completed cause of death (Itel 32. Registrar's sign 0 4 200)	wa h	of Aparle				

State of Maryl

land / Department of Health and M	ental Hygiene	828
Certificate of Death	Reg. No.	 0 1

			State Registrer			Cei	tificate of	Death		Reg. No.			
			Decedent's Name (First, Middle, La	st)					2. Date of De	ath	V	3. Time of Death	
	Physicia			James	C. Ro	ogers			DECEMB	ER 28,	2004	6:02 P M	
	/Medic		4a. Facility Name (If not institution, giv			9-3-02-2	4b. City, Town, o	r Location of Death			ounty of Death	- 	
		·	BELAIR RD & GREM	ACY PARK R	.D		KINGS	VILLE		BAI	BALTIMORE CO		
	Funeral		Social Security Number 6. S		ge (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birthplace (State or Foreign Country)		
	Director		218-60-8786	1ॼM 2□F 4	3	Yrs.	Months Days	Hours Min.	July			ryland	
	D .		Usual Residence of Decedent							·			
	rylar	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
	e Ma	cto	Maryland Har	ford				Forest H	Hill			1 ☐ Yes 2,☐No	
	th th or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	intry?	
	23a		1714 Landmark I	Drive				21050		Uni	ted St	ates	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Items 23a or 28e-f show event. I'm Medical Examination institut at	Funeral	11. Marital Status	12, Was Decedent Armed Forces	Ever in U.S	13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14.	Race - Ameri Black, White,		
٥	after or It	F	1 ☐ Never Married 2 ☑ Married	1 ☑ Yes 2 ☐ If Yes, Give			1 ☐ Yes 🏋 No		, , , , , , ,	5,	pecify:	, 0.0.	
3	ours irel',	d by	3 Widowed 4 Divorced	Year or Dates:			A PARITO			- J	ecity.	White	
215-0036	72 h 'natu	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kind	of Business/Ir	ndustry	
7	ithin Je. Jen.	du	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	d)					
.7	filed within Hygiene. sther then "	S	12 Years]	Logistics	Director			Logist	ics	
Ē	be fill H d otl	Be	17. Father's Name (First, Middle, Last	,				18. Mother's Name					
$\frac{8}{2}$	should be ind Mental is marked o	은	Stanley Willia		Sr.				orothy				
Maryland 2	2 sho and is ma		19a. Informant's Name/Relationship				-	and Number or Run		-			
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Mrs. Carol M.	Rogers/Wii			1 Landmar		Forest			1050	
0	m O		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 ■	Removal from State		ace of Dispo metery, crei	sition (Name of natory or other plac	ce)	Date	20c. Local	tion - City or T	own, State	
Baltimore,	Pages ment of ant: If it ury or o		□ Donation 5 □ Other (Speci			ingto	n Nationa	1 Cem. 1/	10/200	5 Ar	lingto	n, VA	
<u></u>	permit. Page Department Important: It any injury or once.		21. Sign ture of Funeral Service Lice	nsee	00	22 T	Name and Addre	ss of Facility Funeral	Home o	f Dund	alk.In	C	
II)	207		21) 2_ (an	e L			Ave. Du					
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death.							Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	mul	tins	000	Tules	nes)			Onset and Death	
	/Medical		resulting in death)	a. Due to (or as	a conseque	ence of):							
	Examiner			h	8		0						
		Jer	Sequentially list conditions,	Due to (or as	a conseque	ence of							
	cuted id ansif	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
a^	exection and and and and and and and and and an	Exc	resulting in death) Last	Due to (or as	a conseque	ence of):							
98/90	certificate be executed ding physician and se as the burial-transit	cal		d									
	tifical g phy as th	/Medical										7///	
ŏ	2 2 3	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnan		Testania prognana			230	I. Date of deliv	ery	
'n	death e atten ad for u	icia	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a]Ectopic pregnancy] Other (s <i>pecify)</i>			-	Month	Day Year	
Ö	t the by th ache	Physicia	9 🗆 Unknown	9□ Unknown									
J.	The law requires that the death tie has been signed by the atte bage 2 should be detached for	by P	Part II. Other significant conditions	contributing to death I	out not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	the cause of death?	
ecords,	quire n sig uld b								1 🗆	Yes 2XX	lo 3∏Prol	bably 4 Unknown	
၀	w rec	Completed							24a. Was	an 2	4b. Were auto	opsy findings available	
2	he la s has ge 2	m					-			ormed?	death?	ompletion of cause of	
Vital R		e C	25. Was case referred to medical					OO Diseased Death	1 X Yes		Yes	2 No	
5	Physician: The lav this certificate has ral director, page 2	o Be	examiner?	Hospital:	005	D/O-1	ot 3C DOA Oth	er:			70.1 (0.1	. CODIE	
ö		\vdash	27. Manner of Death	28a. Date of Inju	ury :	28b. Time o	i of box	4 Traising 110	28d. Describe			4	
0	ding Ph th. Atter th funeral	tior	1 □ Natural 5 □ Pending	(Month, Da	ay Year)	Injury	Wor	k? Yes 2.5xtNo	Decease	denue	i chea	i hit by	
Division	or Attendatter deatt Director; in by the	Certification:	3 Suicide 6 □ Could not t	De 390 Pinco of In		5:53	eet, factory, office		28f. Location (Street and A	lumber or Bur	al Route Numbrer,	
2	l or At after o Direction by	ertii	4 Homicide determined	building, e	tc. (Specify)		_ 5,		City or To	wn, State) 🥷	plan 120	2 and	
_	Hospital or Attending 44 hours after death. Funeral Director: Atter tely filled in by the funer		29a. Certifier 1☐ Certifying P	hysician: To the best		rledge deat	Occurred at the ti-		s remacy				
	e Hospital 24 hours a e Funeral I letely filled	edical		miner: On the basis of and manner s	of examination								
	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of contifier	A and mainers	- A		29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)	
	F 3 F 8			11-1	YIA			MF			מים סים פ		

30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND, 21201 31. Date filed (Month, Jan Near) 4

OCME

DECEMBER 29, 2004

State

			1 - For Stata Registrar	State of Maryland		rtment of H			giene 0 0	4 41829
	Dhysisi		1. Decedent's Name (First, Middle, Last)					2. Date of De. Month		3. Time of Death
	Physici /Medio		Elizabeth Anne F					Dec.	31, 200	
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		h	4c. County of	
			Forest Haven Nurs 5. Social Security Number 6. Sex		ast hirthday)	Catonsv:	ille If Under 24 Hrs	8. Date of Birt	Baltimo	Pirthplace (State or Foreign
	Funeral Director			M 21 69	Yrs.	Months Days	Hours Min.			Birthplace (State or Foreign Country)
	σ		Usual Residence of Decedent					DEF. /	1933 1	Maryland
	urylan show	_	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	8a-f	octo	MD Anne Arund	lel G	len Bu					1 ☐ Yes 2 ☐ No
	with ti	三	10e. Street and Number			10f. Zip Code	0.63		10g. Citizen of Wha	at Country?
	eath is 234	eral	1115 McHenry Driv	7 C 12. Was Decedent Ever in U.	S 13 V	<u> </u>	061	Specify Yes or No	USA	American Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked othar than "natural; or Items 23a or 28a-f show othar traumatic event, if a Marical Exerting Le notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba □ Yes 2ৢ\ No	n, Mexican, Puer Specify:	to Rican, etc.)	Black,	White, etc. white
Ŏ-0	72 hor	Completed	15. Decedent's Educ (Specify only highest grade	cation		lent's Usual Occupa		deina	16b. Kind of Busin	ness/Industry
7	within one.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	ining .		
2	e filed will Hygien other th		7		C	ptical De		(5: 44: 131:		al Optical
and	be fill	Be	17. Father's Name (First, Middle, Last) John Scott				Anna Z		Maiden Sumame)	
ž	2 should be and Mental Is markad o	7	19a. Informant's Name/Relationship (Ty)	ne Print!	19h Mailin	a Address (Street			er, City or Town, Sta	ate Zin Code)
Maryland	id 2 s ith an 27 Is traul		Terry Repoley - s			McHenry I			-	21061
ē,	s 1 and 2 of Health a item 27 ls othar trai		20a. Method of Disposition	20b. P		sition (Name of natory or other place		Date	20c. Location - Cit	
E O	Pages ent of nt: If i		1 💢 Burial 2 □ Cremation 3 □ R `4 □ Donation 5 □ Other (Specify)	emovarmom State		ge Mem. I		5/2005	Elkridge	MD
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or ot		21. Signature of Funeral Serve License		22	. Name and Addres	s of Facility		9.50	
m	Depa Impo any it		Migh		Ga 72	ry L. Kal 50 Washir	arman Fu noton Bl	neral Ho vd Elk	me@Meado ridge.MI	owridge MP, Inc.
			23a. Part1. Enter the disease, of complishock, or heart failure. List only or	cations that caused the death ne cause on each line.	. Do not ente		,		rest,	interval between
	Physician		Immediate Cause (Final disease or condition	ASP1	RATIC	ON T	NELIM	UNIA		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):					
	ZXammor	<u>.</u>	Sequentially list conditions, b	Due to for as a consequ	ience dft:					
	red	nine	Cause (Disease or injury							==}
,	execun and and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):					
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	dical	,	J						
9	tifical ng phy as th	a a	LE SELVILS							
Вох	eath certific attending p for use as (Physiclan/M	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of	
О.	e dea the at	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)			Month	Day Year
Ρ.	that the de led by the a detached		Part II. Other significant conditions con	tributing to death but not resu	Uting in the ur	derlying cause give	an in Part I	23a Did to	obacco use contribu	ute to the cause of death?
Vital Records,	og Ded	d by	SEIZURE	DISORDER		ladilying cause give	311111 (41)			Probably 4 Denknown
COL	> 0 0	Completed						24a. Was	an 24h We	re autopsy findings available
Re	The law ate has by page 2 sh	dmc						autop perfo	rmed?/ prio	or to completion of cause of tth?
tal		e C	25. Was case referred to medical				26 Place of De	1 ☐ Yes ath (Check only o		Yes 2□ No
>	Physician: this certific ral director,	o B	examiner?	lospital:	ER/Outpatien	t 3 DOA Othe	ar I		lence 6 Other	(Specify)
οľ		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at		now injury occurred	.,,
Ö	Attanding r death. actor: After by the fune	atic	1 Datural 5 Pending 2 Accident investigation	(,	,2.,		Yes 2□No			
Division	or Attancater death	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	et, factory, office		28f. Location (S City or Tox		or Rural Route Number,
	Hospital or 24 hours afte Funaral Dir tely filled in	O								
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	ledical	(Check only 2 Medical Examir	ner: On the best of my knowner: On the basis of examinat and manner stated.		estigation, in my or	oinion, death occi	urred at the time,	date and place, and	d due to the cause(s)
	To To To To To	Σ	29b. Signature and title of certifier	600		29c. License			29d. Date signed (#	nonth, Day, Year)
			Jasueu !	Jullan		リカス	8375		1/3/0	2
_	0		30 Name and address of person/who co	KHANI,	1220	PARK	HEIGH	Hs Av	E BAR	10 MD21208
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 4 200	3. Registrar's Signa	A CONTRACTOR	all!				

State of Maryland / Department of Health and Mental Hygiene Reg. 2004 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last)
 PAUL MARTIN SEBESTA **Physician** December 31, 2004 8:45pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Greater Baltimore Medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-8-1914 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2 ☐ F **Funeral** Days Hours Min. WISCONSIN 171-18-5882 90 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10b Counts 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 No ROSEDALE Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", or Items 23a c any injury or other traumatic event, the Medical Examinar must be once. 821 ROSEDALE AVENUE 21237 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates: 1934-45 Completed by 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LORD BALTIMORE CLEANERS FLEET SUPERVISOR 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK SEBESTA (UNKNOWN) JULIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN EIKENBURG/EXECUTOR 951 ROSEDALE AVENUE ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 1-4-2005 BALTIMORE, MD GARDENS OF FAITH 21. Signature of Funal Service Lines 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 1 day /Medical Due to (or as a consequence of): **Examiner** 071 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit ulcers Decubitus Due to (or as a consequence of): attending physician Box 68760. pe Physician/Medical pulmonuy the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ heart facture 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No arteny 24a. Was an heart disease multivalrular 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

28b. Time of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D047223 1-1-2005 mo Suite 5218 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen M. Piper Charles St. Baltimue MD 21204 6701 31. Date filed (Month, Day, Year) JAN 0 4 2005 egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

			For State Registrar		State of	Marylar		artmen rtificate				fental Hyg	iene ()	4 1	1831
I	Physici	an	1. Decedent's Name Mary P.									2. Date of Deal Month December	h 11 200	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If	not institution	, give street and nun	nber)		4b. City,	Town, or	Location	of Death	DOTING		ity of Death	12:10pm ^M
					e Crofton, M	10				n MD	0.711				Arundel
	Funeral Director		5. Social Security No. 180-03-826		6. Sex 1 ☐ M 2 🖾 🗶	7. Age (In yrs. 94		If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Sept. 5,	Year) 1910	9. Birth Cou	place (State or Foreign intry)
	pu 🛦		Usual Residence of 10a. State	Decedent 10b. County		10c Cir	ty, Town or Lo	ocation				1			10d. Inside City Limits
	the Marylar 28a-f show notified at	tor	MD		e Arundel	100.01	ty, TOWN OF E		ofta	n Mary	1and			i	1 ☐ Yes 2 ₩
	€ 5 3	Funeral Director	10e. Street and Num					10f. Zip				1	0g. Citizen o	f What Cou	intry?
	s 23s	eral [ordon Ave		deat Ever in II	10 10	Was Deser		21114		acifu Vac as bla	14 D	USA	ican Indian,
(0	after dea or itams	Fune	11. Marital Status 1 ☐ Never Marrie	ed 2 Marri	Armed For ed 1 ☐ Yes	2 No		_				ecify Yes or No- Rican, etc.)	В	lack, White	
215-0036	"natural", o	d by	3 X Widowed		If Yes, Giv Year or Da	e ates:		1 ☐ Yes		Specify.			Spec		white ————
15-	in 72 t	Completed		, , , ,	t grade completed)		16a. Dece (Give	dent's Usua kind of woi DO NOT us	il Occupa rk done d se retired,	ation <i>Juring m</i> os)	st of work	ing	16b. Kind of	Business/li	ndustry
212	filed within Hygiene. other than "i	Com	Elementary/Secor	ndary (U-12)	College (1	-40r 5+)		Owner					Retai1		Shop
and	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms	Be	17. Father's Name (First, Middle, . chura	Last)					18. Moth		e (First, Middle, I Donish	Maiden Suma	ame)	
Maryland	should nd Men marke umatic	T _O	19a. Informant's Na	me/Relationsl	nip (Type, Print)		19b. Maili	ng Address	(Street a	and Numb		al Route Number	City or Tow	n, State, Zi	p Code)
	1 and 2 Health a Iem 27 Is		Robert Sha		Son					we, C	-	n Maryland			
Baltimore,	Pages 1 au nent of Hea int: If item iry or otha			Cremation	3 Removal from	State	Place of Dispo cemetery, crea John By	matory or o	ther plac				20c. Location		
ıltir			' 4 □ Donation 21 Signature of Eur		_{licensee} Victor		T 2:	2. Name an	d Addres	s of Facili	itv		Summit	HIII.	PA
B	parmit. Departr imports any inji		Ore	3	> 1001	r. Iuda	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	arles Ol Eas	L. St t For	evens t Ave	Funer	ral Home, Baltimore	Inc. Marylan	d 21	230
			23a. Part 1. Enter th shock, or hear	ne disease, or nt failure. List	complications that cannot one cause on e	aused the deat ach line.									Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (disease or condition resulting in death)		-a. Pu	mon	-	Ed	an	19					Dweek
	Examiner				Due to (er as a consec	uence a)	FFU	510	ns					2 weeks
	p #	ner	Sequentially list con cause. Enter Under Cause (Disease or	nditions, Insulate rlying	Directo (or as a nonsec	nuenna of):	1			7				1
	cate be executed by sician and the burial-transit	Examiner	that initiated events resulting in death) L		c. Due to (or as a consec	atic	<u>_</u>	une	7	-CLM	0			UNKNOWN
8760,	te be e ysiclar ne buri				d	_									
9	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:		222 16.022 201										
Вох	eath certific attending pl	cian/	23b. Was decedent in the past 12 1 \(\sum \) Yes	months?		inth 2 ∏ Feta ant at time of o	al death 3	Ectopic pr						ate of delivitionth	rery Day Year
P.O.	that the de led by the a detached f	hysi	9 Unknown	TINO	9□ Unkno	wn						-			
	ires this signed I be de	by	Part II. Other signifi	icant condition	ns contributing to de	eath but not res	sulting in the u	inderlying c	ause give	en in Part I	l.	23e. Did tob	_	ntribute to 3€Pro	the cause of death? bably 4 □Unknown
Records,	w require been si should l	Completed										24a. Was a	1	1	opsy findings available
Re	o ~ a	omp										autops	V	prior to co death? 1 \(\text{Yes}	empletion of cause of
Vital	iclan: Th certificate rector, pag	BeC	25. Was case referr	red to medical							e of Deat	h (Check only on			
of\	Physician: this certific ral director,	은	1 Yes 27. Manner of Death			-	ER/Outpatier		-	4 11/1/	ursing Ho	ome K Reside	nce 6 🗆 O	(-/	fy)
ion	Attending F r death. sctor: After by the funer	atlon	Natural 2 Accident	5 🗌 Pendin investig	9	of Injury h, Day Year)	Injury	м	8c. Injury Work	ດີົ່ Yes 2⊡	No		,		
Division	i or Attendati after deati Director; i in by the	Certification;	3 Suicide 4 Homicide	6 Could ndeterm	ined 286. Place	of Injury - At h	ome, farm, st	reet, factory	, office			28f. Location (St City or Town		nber or Rur	al Route Number,
Q	pital constant of the pital of		29a. Certifier	Certifyin	g Physician: To the	hest of my kno	owledge deat	h occurred	at the tim	e date a	nd place	and due to the co	use(s) and r	nannar as	stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical		2 Medical	Examiner: On the ba	asis of examina	ation and/or in	vestigation,	in my or	oinion, dea	ath occur	red at the time, di	ate and place	and due	to the cause(s)
	To the within To the comp	M	29b. Signature and	title of certifie	210			290	_	number	0 =	2	9d. Date sign	1 1	Day, Year)
	1			1	010		>	Policy	DE	261	99		12	131	04
	15		30. Name and address 2/9/ 00	So-OS 0	which was	e of death (Iter			Ron	ton	m	arylan	2 3	-111	4
	Sta		31. Date filed (Mont			gistrar's Sign	ature La				1	0		-	
	Registi	ar	75	MA A #	TANA TOO	you por	A	-600							

		_	For State Registrer	State of Maryland / [Certificate of Deat	h	Reg. No.	41032
	Physicia	132	Decedent's Name (First, Middle, Last)	^		2. Date of D Month	Day Year	3. Time of Death
	/Medic	al	Lashawn, (street and number)	4b. City, Town, or Locatio	Decem	ber 30 200 4c. County of Dea	
	Examin Funeral		Johns Hopkins E 5. Social Security Number 6. Sec	agriew Medical (Cott Baltimon thday) If Under 1 Year If Und Months Days Hours	e, Marylance er 24 Hrs. 8. Date of B	}	thplace (State or Foreign ountry)
	Director		217-86-8059]м 2⊠г 37	Yrs.		2-1967	Md
	vland ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limits
	Mary a-f sh iffed	tor	Md	N/A Balt	0			1 XYes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	s 23s	rail	4517 Pall Mall R		21215	Origin? /Consider Von as N	U S A	orican Indian
21215-0036	be filed within 72 hours after death with the Maryland nta! Hygiene. od other then "naturel", or Items 23a or 28a-f show event. The Medical Exam har must be notified at event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic of If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specify Cuban Specific No. 1 ☐ Yes 2 No. Specific No. 2 ☐ Yes 2 ☐ Y	can, Puerto Rican, etc.)	Black, Wh.	
2-0	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grad		Decedent's Usual Occupation (Give kind of work done during m	ost of working	16b. Kind of Business	/Industry
121	within ene. then *	iduu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired) Clerk		M & T Ba	ınk
	e filed within al Hygiene. I other then ' vent, the we	Be Co	12th grade 17. Father's Name (First, Middle, Last)	N/A		ther's Name (First, Middle	e, Maiden Sumame)	
lan	should be ad Mental marked o	To B	Ronald J. Stewart		M	yra Makel		
Maryland	2 S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationship (Ty		. Mailing Address (Street and Nun			
	1 and Health em 27 sther tr		Ronald J. Stewart 20a. Method of Disposition		2924 Edgecombe of Sixposition (Name of	Date	20c. Location - City o	
nor	ages int of h t: If ite y or o'		1 Surial 2 □ Cremation 3 □ F '4 □ Dopation 5 □ Other (Specify)	Removal from State cemeter	ry, crematory or other place) g Memorial Park		Randallstov	
Baltimore,	permit. Pages 1 and Department of Heall Importent: If item 2 any injury or other once.		21. Signatur of Funeral Service Licens		22. Name and Address of Fac		h F/H West	
	- *		23a. Part1. Enter the disease, or compl shock or heart failure. List only o	ications that caused the death. Do				Approximate Interval Between
Ш	Physician		Immediate Cause (Final disease or condition	Sensis				Onset and Death
H	/Medical Examiner		resulting in death)	Due to (or as a consequence		1		17.1
4	Lxammer	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	resistant (enteroco	2005	17 days
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			olysis so	ndromo	9 days
0,	tificate be executed g physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a consequence				
58760,	cate be	dical	•	End Stage F	luto lamure l	Deficiency	Syndrone	6 months
_	attending p for use as	a a	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of de	livery
P.O. Box	D 0 D	Physician/M	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{PNo} \) 9 \(\text{Unknown} \)	1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
Vital Records, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	I I I	n the underlying cause given in Pa		tobacco use contribute l Yes 2 ☑ No 3 ☐ P	o the cause of death?
eco	law as b	Completed				24a. Wa		utopsy findings available completion of cause of
E B	The ate ha	Ē				pert 1 ☐ Yes	formed? death? 2⊌No 1□Ye	s 2010
50	' CO LL	ပိ						
\leq	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	dospital:	Other	ace of Death (Check only		
of	ysicien: is certific director,	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending		Other	Nursing Home 5 Res		ecify)
Division of Vi	ysicien: is certific director,	To Be	examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	utpatient 3 DOA Other: 4 Time of anjury M 1 Yes 2	Nursing Home 5 Res 28d. Describe	sidence 6 Other (Spe	
of	Hospital or Attanding Physicien: 4 hours after death. Funerel Director: After this certific ely filled in by the funeral director.	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, fa	utpatient 3 DOA Other: 4 DTime of njury at Work? M 1 Yes 2 arm, street, factory, office	Nursing Home 5 Res 28d. Describe No 28f. Location City or To	idence 6 Other (Spin how injury occurred (Street and Number or Fown, State)	du <i>ral Route Number,</i> s stated.
of	ing Physicien: After this certific uneral director,	To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, fabuilding, etc. (Specify) sician: To the best of my knowledginer: On the basis of examination ar	Utpatient 3 DOA Other: 4 Time of njury 28c. Injury at Work? M 1 Yes 2 arm, street, factory, office e, death occurred at the time, date addor investigation, in my opinion, of 29c. License number	Nursing Home 5 Res 28d. Describe 28f. Location City or To and place, and due to the leath occurred at the time	idence 6 Other (Spin how injury occurred (Street and Number or Fown, State) e cause(s) and manner a date and place, and du 29d. Date signed (Mon	s stated. e to the cause(s) th, Day, Year)
of	Hospital or Attanding Physicien: 4 hours after death. Funerel Director: After this certific ely filled in by the funeral director.	edical Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, fabuilding, etc. (Specify) sician: To the best of my knowledginer: On the basis of examination and manner stated. Medical	Utpatient 3 DOA Other: 4 Time of njury 28c. Injury at Work? M 1 Yes 2 arm, street, factory, office e, death occurred at the time, date addor investigation, in my opinion, of 29c. License number	Nursing Home 5 Res 28d. Describe 28f. Location City or To and place, and due to the leath occurred at the time	idence 6 Other (Spin how injury occurred (Street and Number or Fown, State) e cause(s) and manner a date and place, and du 29d. Date signed (Mon	s stated. e to the cause(s) th, Day, Year)
of	Hospital or Attanding Physicien: 4 hours after death. Funerel Director: After this certific ely filled in by the funeral director.	edical Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, fabuilding, etc. (Specify) sician: To the best of my knowledginer: On the basis of examination and manner stated. Medical Declaration mpleted cause of death (Item 23a)	Utpatient 3 DOA Other: 4 Time of njury 28c. Injury at Work? M 1 Yes 2 arm, street, factory, office e, death occurred at the time, date addor investigation, in my opinion, of 29c. License number	Nursing Home 5 Res 28d. Describe No 28f. Location City or To and place, and due to the leath occurred at the time	idence 6 Other (Spin how injury occurred (Street and Number or Fown, State) e cause(s) and manner a date and place, and du 29d. Date signed (Mon	s stated. e to the cause(s) th, Day, Year)

1- For Amend Item#16a, per FH, C839, 1/4/05 CC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 650 Month Day 30 2004 **Physician** december William /Medical 4b. City Town, or Location of Death 4c. County of Deeth Facility Name (If not instituțion, give ștreet and number Examiner Mariner Neatth of MIY If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. M 2DF 120-01-1890 New Director YORK Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County ust be notified at 1 ☐ Yes 2 No Completed by Funeral Director HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21015 reen blade 1802 12. Was Decedent Ever in U.S. Amped Forces? 1 Yes 2 □ No Wes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: The Musical Extern 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Buther BUTCHER . Pages 1 and 2 should be filed with the pages 1 and Mental Hygie tent: If item 27 is marked other 1 jury or other treumatic event, It other Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be candiffic MONIO errinina 2 Hnna Sormant's Name/Relationship (Type, Print)

ilda Sandiffio-wif 19b. Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code) Boldin MD 210 1802 Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Importent: If it any injury or o Burial 2 Cremation 3 Removal from State HARFORD MEMORIAL GARDENS 1-3-05 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 3NEW PORT DR. FORESTHIK LAIR. MD 21050 23a. Part1. Enter the disease, of complina onsand caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e-cause on, ach line. Approximate Interval Between Onset and Death Physician ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MULTINFARCT DEMENTIA 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MELLITUS autopsy performed? certificate 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Matural 5 Pending 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2. To the F the 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certifier MAGA D 25027 DECEMBER 30, 2004 prior MB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) XVENUE AR NORTH egistrar's 5 Car)4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Ng 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vaar Physician Shaulis December 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Days Months Hours 1□M 2\□F 82 Director July 3. 1922 South Carolina 218-30-5593 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Modical Examination was the motified at 1 X Yes 2 ☐ No Md. Baltimore Director N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2611 Eastern Ave. 21224 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. 8m 27 is marked other than "natural, or Iter 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: White 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Rider Grace Ebernickel ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Melisa Clampitt/Daughter 316 Benfield Rd., Severna Park, Md. 21146 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō = 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) OakLawn Cemetery 12-29-04 Balto., Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bradley-Ashton-Matthews, Inc., Md. 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease est only one cause on each line shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner the burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □ Yes 2 □ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, fauluro 1 Yes 2 No 3 Probably 4 Stonknown Completed tract infection 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 No or Attending Physicien; after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Unpatient ieral Director; After this c filled in by the funeral dire 0 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide o the Hospitel 24 hours a 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State

Registrar

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4940

7 MD KOSBOROUGH

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

JAN 04

23014

Eastern Ave Baltimore

State of Maryland / Department of Health and Mental Hygien ? For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dec 28, 2004 2:30 Pm. Vera H.V. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore University Of Maryland Medical System Date of Birth (Month, Day, Year) Nov 17, 1940 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Min 1 M & F Days Hours Maryland Director 217-38-9825 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show ust be notified at Yes 2□No Baltimore Director N/A Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5 U.S.A. 21217 2007 N. Pulaski Street Itams 23a 2 should be filed within 72 hours after death v n and Mental Hygiene. is markad other than "natural", or Itams 236 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status other traumatic avant, the Mudical Expulling to Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Black Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Police Department Elementary/Secondary (0-12) College (1-4or 5+) Office Supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Forbes Joseph M. Forbes Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an 2007 N. Pulaski Street Baltimore, Maryland 21217 Department of Health a Important: If itam 27 is any injury or othar tra Roland Smith Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, Maryland 01/04/05 Maryland National Memorial Park 4 ☐ Donation 5 ☐ Other, (Specify) 21. Signa Lus of Fundal Syrice Li 22. Name and Address of Facility Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Respiratory Hute disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1x Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) within 24 hours a To tha Funaral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P16488 IMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daphne Friedman 22 South Greene Street Baltimore, Maryland 21201 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrer	State of Marylar		artment of H			iene 0 0 L	41836
			Decedent's Name (First, Middle, Last)					2. Date of Dea	th	3. Time of Death
	Physici /Medic		Aubry S	SHAW				Month Decembe	Pay Year 27, 200	M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	-	4c. County of De	ath
			3376 Chiswick Cou			Silver	Spring If Under 24 Hrs.	0 D 4 D' 41	Montgo	
п	Funeral		5. Social Security Number 6. Security Number	M 2□F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
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	how		10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Be-f s	Director	Maryland Montgome	ry	S	ilver Spi	ing			1 ☐ Yes 2 🔀 No
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	d within 72 hours after death with the Maryland Jiene. r then "neturel", or Items 23e or 28e-f show the Medical Eva front for rodified at	erai	3376 Chiswick Cour	t B1d. 52, Ap		20906	spanic Origin? (Spe	ecify Yes or No-	United S	tates merican Indian,
	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	1	f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, W	
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and	e da fa	Be C		Shaw			Unkno	,	,	
Maryland	d 2 should be th and Mental 7 Is marked o treumatic eve	L 2	George 19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Street			r, City or Town, State	J, Zip Code)
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altimore,	ges 1 and 2 of Health a If item 27 Is or other tree		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City	or Town, State
Ē	Pages nent of ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Wes	st Arun	del Crema	atory 12/3	30/2004	Odenton,	Mary1and
at	permit. Page Department o Importent: If any injury or once.		21. Signature of Funeral Service Licens	ee 1	G G	. Name and Addre	ss of Facility Crematio	on Servi	ce P.O.	Box 784
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ū		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe h	ow injury occurred	
Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be	29 Place of Injury At h	omo form et		Yes 2 □ No	28f Location /S	treet and Number or	Rural Route Number,
Σ	for Attendater death Director:	ertif	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	eet, laddry, office		City or Tow		Tibras Troble Trasmocr,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier Certifying Phy	vsicien: To the best of my kn	owledge, death	h occurred at the tir	me, date and place,	and due to the o	ause(s) and manner	as stated.
	the hin 24 the f	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mo	
	To To	-	250. Signature and title of certifier	2/1						
	, 21		20 Nemada additional	omitted cause of death (te	m 23a) /T	Print)	34190		Decembe	r 27 2004
	101		30. Name and address of person who co	Reilly	3418	Oland	word cT	#/11	Olaseus	nD 20832
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	W TOO			7.00	
	Regist		JAN 0 4 2005	prem s	ALLEN					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 31. 2004 4:45 P^{M} December Veronica K. Sprows /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Morningside House of Friendship Hanover 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 21/2 F 214-30-3907 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County other treumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ▼No Completed by Funeral Director Dundalk MD. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23e or 21222 USA ₹. 3432 McShane Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 ▼ No Specify Specify: White 3 Widowed 4 ☐ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department Store 8 years Salesperson 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi and Mental F is marked ot Elena Cassidy John Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Department of Health a fmportent: If item 27 is eny injury or other tree one. 6941 Cumberstone Place, Gainesville, VA. 20155 Joseph Sprows Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Sacred Heart Of Jesus Cem. 5, 2005 Dundalk, Md. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown يە 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vital Records, 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 TYes 2 □ No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 NOther (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 No after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai completely within 2 To the 29d. Date signed (Month, Day, 29c. License number 29b. Signature and title of certified 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4 2005

Registrar's Signature

32

State of Maryland / Department of Health and Mental Hygiene 00 [1 838 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Leslie Woodward Stanton December 30, 2004 4:15 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 104 Jumpers Circle Perry Hall Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Days 215-03-4327 Yrs. Nov 5, Maryland Director 92 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Directo Maryland Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 104 Jumpers Circle 21236 USA "naturel", or Items 23a Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "na eny injury or other traumatic event (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baking Company Baker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Stanton Ruth Gary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2926 Hoffman Mill Road, Hampstead, MD 21074 Joan L. Gailey, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 01/03/2005 * 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Fun ral Service Licensee, 22. Name and Address of Facility M-0723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atheroscheshie COLONY 20701 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Box 68760. attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 8 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerel 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) Rel J. Man mo 132883 93 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Center Or Reinfronton Ml 2/130 Robert 31. Date filed (Month, Day, Year) 32. Registrar's Signature State eren di Aportes 4 Registrar

				Department of Health and Mo Certificate of Death		04 41839
			Registrer 1. Decedent's Name (First, Middle, Last)		Reg. No. 2. Date of Death	3. Time of Death
	Physici /Medic		AMELIA	TYLER		Yeer 12:15 A M
	Examin		4a. Facility Name (If not institution, give street and number) FUTURE CARE OURT	4b. City, Town, or Location of Death RANDALCSTOU	4c. County o	
	Eurovol		FUTURE CARE OFF COURT 5. Social Security Number 6. Sex 7. Age (In yrs. last bir.		8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		115-50-9507 10M 20 F 70	Yrs. Months Days Hours Min.	(Month, Day, Year) 10 - 18 - 34	Joeria W. Africa
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	Maryl -f sho	ţō	MD Pattimore	Patumone		1 ☐ Yes 2 ☑ No
	or 28g	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of W	hat Country?
	s 23e	rail	13311 Woodripple, Kwad	21244	<u>US</u>	1
' 0	fter de	Funeral	11. Marital Status 12. Was Decedent Eyer in U.S. 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ Narried	13. Was Decedent of Hispanic Origin? (Specify Croan, Mexican, Puerto F	Rican, etc.)	- American Indian, , White, etc.
21215-0036	72 hours after death with the Maryland natural', or items 23s or 28s-f show lited Examiner must be incliffed at	þ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 12 No Specity:	Specify:	BIACK
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b. Kind of Bus	siness/Industry
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Maryland	ould be I Mental narked c	L _O	Nilkens Tyler	Louise	Turkett	
Mai	and 2 sho eaith and n 27 is m		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or Rural	Politimurs N	10 Code)
re,	of Health Item 27 other tr		cometer	Disposition (Name of Day, crematory or other place)	ate 20c. Location - C	City or Town, State
Baltimore,	Pages ment of i		1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Jawn 1-8-6	14 Battime	re MD
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic evant, the Madical Examiner must be indifficed at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Will 8728 Liberty Rol. &	andalstown,	mp 21133
			23a. Part1. Enter the cisease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
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s, P	The law requires that the site has been signed by the bage 2 should be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in		23e. Did tobacco use contrib	oute to the cause of death?
ord	w require been sig should b		ATRIAL FIBRILLATIO	N	1 ☐ Yes 2 ☐ No 3	3 ☐ Probably 4 ☐ Unknown
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n of	their ne			njury Work?	8d. Describe how injury occurred	d
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	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	dor investigation, in my opinion, death occurred	nd due to the cause(s) and mand d at the time, date and place, ar	ner as stated. nd due to the cause(s)
	To th within To th comp	Me	29b. Signature and affile of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
)	L		M.D		DECEMBE	29 2004
	3		30. Name and address of person who completed cause of death (Item 23a) (LEONARD RICH ARPSON 5622 BACTIMO)	(Type, Print) OF NATIONAL PLLE #412	RAITIMONIE	71778
	Sta	ite	31. Date filed (Month, Day, Year) 2005	RE NATIONAL PICE #603	1	-16-0
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			1 - For State Registrar	State of Maryla		ent of Health and ate of Death		ie2e0 0 [4	+1840
	Physic /Medi		1. Decedent's Name (First, Middle, La	ast)		TRUSTY	2. Date of Deat Month	h Day Year	3. Time of Death 16:36 M
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Baltimore, Mai	permit. Pages 1 and 2 sho Department of Health and Importent: If item 27 te many injury or other treum		19a. Informant's Name/Relationship (20a. Method of Disposition 1 Aurial 2 Cremation 3 Company of	Trusty 20b. Removal from State (%)	Place of Disposition (cometery, crematory)		ton St	Balto. 1 20c. Location · City or To Landou	Nd. 2/22:
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Vital	Phyeician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	EB/Outputient 20	Othor	eath (Check only on		
ō	ding h. After fune	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		nce 6 □Other (Specify w injury occurred	/)
Division	F 6 F C	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, fac ify)	tory, office	28f. Location (Str City or Town	reet and Number or Rura , State)	l Route Number,
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)	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Me	29b. Signature and title of certifier	7		29c. License number RESOOO		9d. Date signed (Month, ECEMBER, ZZ	
	7	25	30. Name and address of person who NICOLA ZETOLA	completed cause of death (ite	m 23a) (Type, Print)	TAL MARYLAN	FE STREET	BALTIMOR	26
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Maryla		artment rtificate			and M	lental Hyg	jiene	104	41841
	Physicia /Medic	an	Decedent's Name (First, Midd MARY		TURNER						2. Date of Dea Month DECEMBE	R 22		3. Time of Death 3:40 P M
	Examin	er	4a. Fecility Name (If not institution PRINCE GEOR	GE'S HOSP	ITAL		C	CHEVI				PRI	County of Death	ORGE'S
	Funeral Director		5. Social Security Number 218-24-7379 Usuel Residence of Decedent	6. Sex 1 ☐ M 23C F	7. Age (In yi	rs. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day June 27	1922	9. Birth Cou 2 West	place (State or Foreign ntry) Virginia
	e Maryland a-f show	ctor	10a. State 10b. Count	e George'		City, Town or Lo								10d. Inside City Limits 1 √Yes 2 □ No
	th with th	ai Dire	10e. Street and Number 1203 Gondar Av	enue			10f. Zip		0785			10g. Citize U . S	en of What Cou	ntry?
900	be filed within 72 hours after death with the Maryland ntal Hygiene. sd other than "natural", or Iteme 23a or 28a-f show event, the Medical Examinar must be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried 1 ☐ Yes	2 🔯 No ive		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: Bla	etc.
Maryland 21215-0036	within 72 h iene. r than *natu the Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 8th	nt's Education est grade completed, College () (1-4or 5+)	16a. Dece (Give life. Dome:	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	ition Juring mos.)	t of work	ing		d of Business/Ir ivate	ndustry
land 2	should be filed vad Mental Hygie marked other I imatic event, II	To Be C	17. Father's Name (First, Middle Walter B. Turr						18. Mothe		e (First, Middle,			
Baltimore, Mary	t. Pages 1 and 2: rtment of Health ar rtant: If item 27 Is njury or other trau		19a. Informant's Name/Relation Lena Turner Ba 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (21. Signature of Funeral Service	arnes/Daug 3 □Removal from Specify)	State 20b	145 Place of Disponentery, creditarmony	Straign (Name of the Communication (Name of the Communication)	ght land of the place	Rd Ro	anok 1 1/5/(Date	s, No 20c Loca Lando	orth Ca ation - City or T ver ,Mar	rolina 2782 own, State
	Physician		23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition	or complications that st only one cause on	caused title de	-	7474 I	Lando	ver	Road	Landov	er, N	Marylan	Approximate Interval Between Onset and Death
8760,	/Medical Examiner bhysician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	1	ing	equence of):	l so	in	al	al	Cer_			weeks weeks
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	w requires that the sbeen signed by the should be detache	by	Part II. Other significent condit	ions contributing to	death but not a	resulting in the u	inderlying ca	ause give	en in Part I			es 2		the cause of death? bably 4 Honknown
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	<i>y</i>		30. Name and address of person Jacob S 31. Date filed (Month, Day, Yea	Akras	use of death (I Segistrar's Sig	Prince	- 0	eor	je	lfos	pilal	Che	overly	MD
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20c,perfh.G839 1/4/05 TT

State of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of Maryland / Department of Health and Mental Hygie performance of the state of th 1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** lawnes 10 Mes OL 10069 M 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buthnow Sucovis HUS N/A

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 10M 20F 21450 3684 56 Yrs. Director 31,1948 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f show the Medical Exampler must be notified at N/A Baltimore Maryland 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1120 Somerset Street 21202 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 🎾 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes Ž☐ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 11th grade Construction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any injury or other traumatic event OREs. Paul Webb Ruth Betts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gloria Townes/ Wife 2522 Robb Street Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, State MD Garrison Forest Vet. Cem. D Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Mary * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Euneral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1 Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so con the order failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Empoles 11 **Physician** /Medical Due to (or as a consequence of): Examiner 0 アフィら Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2/2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1. Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Many er of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) V0060292 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Semo Hockital 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 0 4 2005 Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	Cer	irtment of H tificate of I	leaith and iv Death		leg. No.	41844
	Physicia	an	Decedent's Name (First, Middle, Last)					2, Date of Dea Month		3. Time of Death
	/Medic	al	Lorrene Elizabet 4a. Facility Name (If not institution, give s		Tapkin		Location of Death	Decembe	er 30, 2004	
	Examin	ier	Genesis Multi Me			Towson	Location of Death		Baltimo	
	Funeral Director		E Coolel Cooughy Number 6 Cov	м 2 X F 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 20	9 Bi	nthplace (State or Foreign country)
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	a-f sho	tor	MD Baltimor	9	Τοω	son				1 ☐ Yes 2 🖔 No
	or 28	Direc	10e. Street and Number	•		10f. Zip Code			10g. Citizen of What C	ountry?
	eath w	Funeral Director	7513 Far Hills Dr	LVE 2. Was Decedent Ever in L	IS 13 V	21286	isnanic Origin? (Sp.	acity Yes or No-	USA 14. Race - Am	erican Indian
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23a or 28a-f show other treumatic event, If a Medical Extractive to that be rediffed at	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	i	Yes, specify Cuba	ispanic Origin? (Sp. in, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh	
0-617	hin 72 hou e. en *nature Madical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work I)	ing	16b. Kind of Business	s/Industry
7	ygiene ygiene her the		12			Homemake		(7° - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Own 1	lome
yland	id be fil ental H ked oth c even	To Be	17. Father's Name (First, Middle, Last) Clarence Julius Ho	ofmann			18. Mother's Name Emma I:		maiden Sumame) Icker	
Mary	shoul and Me s marl	F	19a. Informant's Name/Relationship (Typ	ne, Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	r, City or Town, State,	Zip Code)
<u> </u>	l and 2 lealth m 27 I		Wanda Fazenbaker/	daughter 200	7513	Far Hill sition (Name of natory or other place	s Drive	Towson,	MD 21286 20c. Location - City o	
	ages 1 ant of H it: If ite y or ot		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Ri '4 □ Donation 5 □ Other (Specify)				ery 01/0		Elkridge,	
Dallimor	permit Pages 1 and 2 Department of Health a Importent: If item 27 it any injury or other tre		21. Signature of Ameral Service Linn		22	. Name and Addres	ss of Facility R	uck Tows	on Funeral	Home, Inc.
Ī			23a. Panh. Enter the disease or complice shock, or heart failure. List only on	cations that caused the dea	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	Maryland 21 rest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	End SVGS Due to (or as a conse Consco	e C	rdion	ryopa (7	ny		years
	Examiner		Our resistation flat was distance.	Conse	ture	heart	· Falle	ne		years
	bed is it	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence of):					
ĵ	tificate be executed g physician and as the burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a conse	quence of);					
00/00	cate be ohysicia the bu	edical								
O X O	nding guse as	-	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr		15.4			23d. Date of de	alivery
<u>.</u>	w requires that the death cent been signed by the attendin should be detached for use	hysiclan/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
ds, r	requires that the	by P	Part II. Dther significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		bacco use contribute t es 2 ☐ No 3 ☐ P	o the cause of death?
spiosa	law red as beer 2 shou	Completed						24a. Was a		utopsy findings available completion of cause of
	sicien: The law s certificate has b lirector, page 2 s	Com						perfor 1 Tes	med? death?	s 2 No
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	7.50/0-4	Oth	26. Place of Deat		ne) ence 6 ∐Other (Spi	
0	Phy this ral d	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	y at		ow injury occurred	9CITY)
VISION	tendin leath. tor: Af the fur	catlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 □ No	Ook Leasting (C	the state and the section of E	hum I Courte Attumber
2	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification;	4 Homicide determined	28e. Place of Injury - At the building, etc. (Spec	nome, farm, str	eet, factory, office		City or Tow	treet and Number or F n, State)	ura.i Houte Number,
	Hospi 24 hou Funer tely fill	edical		ician: To the best of my kn er: On the basis of examin and manner stated.						
	To the within ?	Med	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon	
			> sgupte	MD		000	53150		ec 315t	2004
	5		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	Print)	6303	800,0	and Cita	MO
	Sta		31. Date filed (Month, Day, Year) JAN 0 4 200	32 Registrar s Sign	nature					121076
	Registr		UMN U # /III	17	M Mai	0.0				

Amend item#26, perMR Verbal, G839, 4/05 TT of Health and Mental Hygiene O O I 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1810 21 TVO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltima Itimas 50 DECCAL On Year If Under 24 Hrs. B. Date of Birth Min. Month, Day, Y 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 **Funeral** Months -40-549 1 □ M 2 X F Yrs Director North Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: If item at 73 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, it a Medical Examinant the coefficial at 1 Yes 2 No Funeral Director Maryland mor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Be Completed by Specify: 3 € Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ache 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle. Maiden Sumame 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery crematory or other place) 101 on Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Name and Address of Facility oseph Enter the disease, or complications that, or heart failure. List only one cause on Cause (Figs.) Approximate Interval Between Onset and Death or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failu Immediate Cause (Final disease or condition resulting in death) each line Vasculan archie Physician /Medical Due to (or as a consequence of): **Examiner** ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760 as the t IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 menths? 1 ☐ Yes 2 ☐ No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ģ signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page certificate Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 5 Sther (Specify) 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide .⊆ To the Hospitel pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DWar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOL Menaber an 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 04 2005 Registra

State of Maryland / Department of Health and Mental Hygiene 41846 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 5 Z 9308 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deeth 1Vor HOME Colums19 10 If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, **Funeral** 9. Birthplace (State or Foreign 244-12-3895 Usuat Residence of Decedent Months Days Hours 1X M 2□ F Director North permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mental Hyglene. Important: If Item 27 is marked or other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, Im Medical Exprising must be notified as 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Director 1 Ves 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 If Yes, Give 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify 3 XWidowed 4 ☐ Divorced Year or Dates ac 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use refixed) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) er 17. Father's Name (First, Middle, Last) Maiden Surname) 18. Mother's Name (First, Middle, Be 2 lhoma 19a. Informant's Name/Relationship (Type, Print) (Son) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Md. 21043 20c. Location - City or Town, State homas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Home 2121 W. North Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Rong Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Hospital or Attanding Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ò Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours efter deeth.

To the Funeral Director: After this certiticate hes t completely filled in by the funeral director, page 2 s Z de No TITYES 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ဥ 1 Yes 25 No Other: 2 ☐ ER/Outpatient 3 ☐ DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certification: 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 □ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kazlon Gary 31. Date fired (Month, Day, Year) 32. Begistrer's Signature State Registrar

DHMH 16 Rev 6/95

			For State Registrer	State of M		eartment of Heal			ene2001	+ 41847
			Decedent's Name (First, Middle,	Last)				2. Date of Death Month	***************************************	3. Time of Death
	Physici /Media		Michael	Α.		Upperman		December	Day Yea	00.25DMM
	Examir		4a. Facility Name (If not institution,	give street and number	7)	4b. City, Town, or Loca	ation of Death		4c. County of D	
61		4	Civista Medi		- de de la tradada	LaPlata	Inder 24 Hrs.			Charles
	Funeral Director		217-46-5122	5. Sex 7. A 11X M 2 ☐ F	ge (In yrs. last birthday 59 Yrs.		ours Min	B. Date of Birth (Month, Day, Y October	(ear) 9.1	Birthplace (State or Foreign Country)
	ס		Usual Residence of Decedent					ccoper	J,194J	Washington DC
	anylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	8a-13	Director	Maryland Charle	S		LaP1ata				1 ☐ Yes 2√ No
	with t	DIE	10e. Street and Number 144 Morgans Rid	ge Road		10f. Zip Code 2064	46	10g	g. Citizen of What U.S	•
	ns 23	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.S. 13.			ify Yes or No-		nerican Indian,
9	after o	Fun	1 Never Married 2 Marrie	Armed Forces	?	Was Decedent of Hispan If Yes, specify Cuban, Me		ican, etc.)	Black, W	
99	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	:	1 ☐ Yes 2 ☐ No Sp	ecify:		Specify:	White
21215-0036	filed within 72 hours after death with the Maryland tkyliene. thar than "natural", or items 23c or 28a-1 show that the Medical Exart activitied at	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	edent's Usual Occupation of kind of work done during DO NOT use retired)	g most of working	7	b. Kind of Busine	
7	withii iene. than	dwc	Elementary/Secondary (0-12) 12th	College (1-4or	5+)	bing Contrac		1	R.V. Uppe	erman Sons,Ind
0	Hyg Hyg othar	Be C	17. Father's Name (First, Middle, La	ist)	1,4011			First, Middle, Ma	iden Sumame)	
lar	Jental Jental Irked o	To B	Reginald V. U	pperman, S	r.	V	irginia	E. Roll:	ins	
Maryland	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship			ing Address (Street and N				
	l and fealth im 27 har tr		Beverly J. Upper	man (Wife)		Morgans Ridg	2000			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "natural", or items 23c or 28s-1 show many injury or other traumatic avent, its Medical Exert in activative redilled at any injury or other traumatics avent, its Medical Exert is activated.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3			matory or other place)	Decemb	er 31	c. Location - City	
	permit. Page Department of Important: If any injury or once.		* 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Light			ion Cemeter			linton, l	
B	permi Depar Impoi any ir		May A. A	1 (1						to, MD 20735
	- 1		23a. Pan1. Enter the disease, or co	omplications that cause	ed the deeth. Do not en					Approximate
	Physician :		Immediate Cause (Final disease or condition	AT\	no cleso	tic Coast	12111	ulen la	2/1/200	Interval Between Onset and Death
	/Medical		resulting in death)	a Due to (or as	s a consequence of):	The Court	0 001	wen re	1200	
	Examiner		Sequentially list conditions,	b						
0/	bed issit	iner	Sequentially list conditions, the sequential sequence of the cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of					
	al-trar	Examin	that initiated events resulting in death) Last	c Due to (or as	s a consequence of):					
8/60	cate be executed physician and s the burial-transit	dical		d						
9		Medi	IF CELLAL E							
X Q Q	death certifi e attending id for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		☐Ectopic pregnancy			23d. Date of d	
9	0 0 0	/sic/	1 Yes 2 No	4☐Pregnant a 9☐Unknown	at time of death 5	Other (specify)			Month	Day Year
7.	that the		Part II. Other significant conditions	s contributing to death I	but not resulting in the	inderlying cause given in F	Part I	23a Did tohac	co use contribute	to the cause of death?
Records,	requires that the een signed by th hould be detache	d by	, and the second	,			471.			Probably 4 Nunknown
Ö		Completed						24a. Was an		
Ž Ž	sician: The law certificate has b irector, page 2 s	omp						autopsy performed	d? death?	
VItal	ian: 'i	0	25. Was case referred to medical			26. F	Place of Death (No 1 □ Ye	es 211 No
> 10	\$.≅ Þ	To B	examiner? 1 Tyes 2 No	Hospital: 1 Inpatie	ient 2 ER/Outpatie	Other			e 6 Other (Sp	ecify)
<u></u>	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da				d. Describe how		
200	r Attandi er death. ractor: A by the fu	icatl	2 Accident investigat 3 Suicide 6 Could not	he		M 1 ☐ Yes				
UNISION	E 3 /E C	ertification:	4 Homicide determine	280. Place of in	ijury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	28	City or Town, S		Rural Route Number,
_	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	0	29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge, deat	h occurred at the time, dat	te and place, and	d due to the caus	e(s) and manner a	as stated.
	n 24 h	edical	(Check only 2 Medical Ex	aminer: On the basis o and manner st	of examination and/or in	vestigation, in my opinion,	, death occurred	at the time, date	and place, and du	le to the cause(s)
	To the company	Σ	29b. Signature and title of certifier			29c. License num	ber	29d.	Date signed (Mor	nth, Day, Year)
			1/18)		040	5365		12-28	-2014
	5		30. Name and a dress of person who Michael Sidard			Print) gston Road #	101 F+			
	- Sta	0	31. Date filed (Month, Day, Year)			_	- 101 FL	· wasiiiii	iglon, MD	
	Registr		JAN 0 4 2	005	rar's Signature	West .				

			For State Registrar	State of M	laryland .		artment o				iene	با (41848	
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Ti									3. Time of Death		
П	Physici		Timothy James Wood				Month Dey Yeer							
	/Medic		4a. Facility Name (If not institution, give street and number)				December 26, 2004 12:45 4b. City, Town, or Location of Death 4c. County of Death							
			3764 Bel Pre Ro	ad #13			Silver	Sprin	ıg		Mont	gomer	cv	
	Funeral		5. Social Security Number 6		ge (In yrs. last	birthday)	If Under 1 Yo		er 24 Hrs.	B. Date of Birth (Month, Day,		9. Birth	place (State or Foreign intry)	
	Director		214-60-6583	1 X M 2□F	52	Yrs.	Month o	, iodio		lay 15,	1952		ington, DC	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits	
	Manyl f sho	ō	MD Montgo	marv	Silve								1 X Yes 2 □ No	
	the t	Director	10e. Street and Number	irci y	DIIVE	T OP	10f. Zip Cod	ie		1	On Citizen of	. Citizen of What Country?		
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	ms 2	Funerai	11. Marital Status	12. Was Decedent		13. V	Vas Decedent		Origin? (Spec	ify Yes or No-			ican Indian,	
9	after or ite	F	1 Never Married 2 Married	Armed Forces? d 1 ☐ Yes 2 X		ļ l 1	Yes, specify (Cuban, Mexic	an, Puerto Ri	ican, etc.)	Ble	eck, White,	, etc.	
03	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			☐ Yes 2🏋	No <i>Specit</i>	y:		Speci	^{ify:} Whi	lte	
5	within 72 hours after death with the Maryland one. then "natural", or items 23s or 28s-f show the Medical Examerer must be rediffed at	Completed	15. Decedent's (Specify only highest		11	(Give .	ent's Usual Ockind of work do	ne durina mo	ost of working	7	16b. Kind of E	3usiness/Ir	ndustry	
121	within nne. then	mpi	Elementary/Secondary (0-12)	College (1-4or			00 NOT use re Consult	,			Marada			
7	filed v Hygie ther i		17. Father's Name (First, Middle, La	L sst)	1	Janu	Consul		her's Name /	First, Middle, M	Music			
Maryland 21215-0036	d be ental ced o	o Be	Roderick Austin						ie Mor		naideir Surra	110)		
7	shoul nd Me mari	٦ ک	19a. Informant's Name/Relationship		1	9b. Mailin	a Address (Str			Route Number,	City or Town	State Zi	n Code)	
	nd 2 alth a 27 Is r trat	t l	Juan Carlos Mad	rigal, Comp										
re,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examers must be milling at		20a. Method of Disposition		20b. Place	of Dispos	sition (Name or		Da		20c. Location			
altimore,	Page nent c int: If		1 Burial 2 XCremation 3 4 Donation 5 Other (Spe)		-		12/30	/2004	Brentw	ood.	Maryland	
alti	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		21. Fignatur of Fune at Service Lin	ensee	1		Name and Ac			nple Tr				
m	80 5 5	V V	Want to	Jean ht	1	10)40 Roc	kville		-		Mary1	and 20852	
	- 1		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.											
	Physician		Immediate Cause (Final disease or condition	Esopha									Onset and Death	
	/Medical Examiner		resulting in death)	u	a consequen									
L	LAdiiiiiei		Sequentially list conditions,	b. Hemolyt	ic Ane	mia								
	ed sit	line	if any, leading to immediate cause. Chiter Underlying Cause (Disease or injury											
	and and ti-tran	Examiner	that initiated events resulting in death) Last	art : I ce of):	failure					-				
8760,	cate be executed physician and the buriat-transit	dicai E			,	,-								
687	ificate g phy: as the	edic		d										
Box	death certifii e attending p od for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth							23d. Da	ate of delive	ery	
	deatl	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		Ectopic pregnancy Other (specify)				Month Day Year					
P.0	that the de led by the a detached f	hys	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
	es ti gne be c	by F								23e. Did tobacco use contribute to the cause of dea			he cause of death?	
ord	v requir been s should	ted								1 🗆 Ye	s 2 X No	3 Prob	oably 4 □Unknown	
Records,	law las b	Completed								24a. Was an		Were auto	ppsy findings available impletion of cause of	
		Co								perform 1 Yes 2		death?		
Vital	ysiclan: Th	Be	25. Was case referred to medical examiner?	Mensitel					e of Death	Check onl. one	2			
of	9 0 =	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatie		_	3L DOA			5 X Reside			(y)	
	ding After fune	tion	1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ly Year)	o. Time of Injury	,	njuryat Work? □Yes 2□		d. Describe ho	w injury occur	red		
S	or Attending after death. Director: After in by the funer	lical	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 290 Place of Ini	iury - At home	farm stre				Location (Str	eet and Numl	her or Rura	al Route Number,	
Division	after Dire	ertification;	4 Homicide determine	building, et	c. (Specify)		or, raciory, orri	06		City or Town,	State)	701 01 71010	arriodio riambor,	
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	0	29a. Certifier 1 Certifying	Physicien: To the best	of my knowled	ige, death	occurred at the	e time, date a	nd place, and	d due to the ca	use(s) and m	anner as s	tated.	
	ne Ho	edical	(Check only 2 Medical Ex	aminer: On the basis o and manner sta	f examination ated.	and/or inv	estigation, in m	y opinion, de	ath occurred	at the time, da	te and place,	and due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		,		29c. Lice	ense number		29	d. Date signe	d (Month,	Day, Year)	
)					m	0	D3	35635		D	ecembe	r 28,	2004	
	1		30. Name and address of person wh	o completed cause of c	death (Item 23	a) (Type, F	Print)							
			Joseph Kaplan, M	D, 18111 Pr	ince P	hilip	Drive	, 01ne	y, Mar	yland				
	Sta Registra	te ar	31. Date filed (Month, Day, Age)	4 2005 L	ar's Signature	L	1 4	~						
	negistr	-11			Meser	0	Gentle !	7						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiere 0 0 4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death WILLOUGHBY **Physician** MARLENE Month Year DEC 28 /Medical 4a Eacility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSPIFAL SELONDS RON BAITIMORE CITT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 219-40-1895 1 ☐ M 2 🗷 F Months Days Hours Min Director Usual Residence of Decedent the Maryland 10a State 10b. County show 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatih and Mental Hygiene.
nent of Heatih and Mental Hygiene.
nett. If item 27 is marked other then "neturel", or Items 23e or 28e-f show ury or other treumatic event, If a Medical Examination and the facility of 10d. Inside City Limits 1 Nes 2 No Directo MARYLAND 10e. Street and Number 10g. Citizen of What Country? STREET ASKI by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: ACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EARLY CHILD HOOD EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be AMUEL ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARMEN WILLOUGHBY (DAUGHTER ST. BALTIHORE MD. 21223
Date 20c. Location - City or Town, State 529 N. PULASKI 20a. Method of Disposition
1 Durial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State METRO CREMATORY 12-31-04 ¹ 4 ☐ Donayion 5 Other (Specify) of Fureral Service Ligensee JR. FUNERAL HOME YLTON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAGE CIRR HOSIS of LIVER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner GASTRO LINTESTINA BLEEDING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and on the cause). Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit death certificate be executed HEPATITIS that initiated events resulting in death) Last Due to (or as a consequence of): TY DRAFION Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manper of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funerel Director: After 1 Natural
2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AFTENDW 9 D0053948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 522 DOLPHIN STREET TANSINDA JANES MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 4 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygion [] [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Yeer 4.30 PM December 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNIS . Social Security Number 217:58:7331 **Funeral** 1 M 2 F Days Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City Town or Location itam 27 is marked other than "natural", or Itams 23s or 28a-f show other traumatic event, the Medical Exercices must be redified at 1 Yes 2 No Director 10g. Citizen of What Country? Completed by Funeral 14. Race - American Indian, Black, White etc. 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ges 1 and 2 should be filed within t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HEAUTHCARE NURSE 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, N. WOLFE HACIIMOKE, NAXYLAND 21213 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Date permit. Page Depritment Important: If any njury or once. GREENMOON'T CREMATORY 12.29.04 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PIKE BALTO, MD 21229 BAUTI MORE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician URGAN Ressive week /Medical **Examiner** monari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🔼 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Yes 21**5**0No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 patient 1 ☐ Yes 2 No Other: 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funaral Director: After 5 Pending investigation Natural 2 Accident 1 🗀 Yes 2 🗆 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 128 S-000 DECEMBER 20, 2004 30. Name and address if pe son who completed cause of death (Item 23a) (Type, Print) 5. BENJAMIN Brooke 5+. 600 N. WOLFE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 19a par fib 839 1 4-05 yt Health and Mental Hygiene 1 1.

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Month Day 29, 200 Physician a M E /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 3 1 M 2 XF 215-21-Yrs GINIA Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Ves 2 □ No Director MARYLAND 10e. Street and Number 10g. Oitizen of What Country? 59 HEIGHTS 00 102 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE PROVIDER RETAIL 11+HGRADE LEATHER GOODS STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental EDCO 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) August James W. Watts (husband) 429 KALTON COURT, PIKESVILLE MD 21208 permit. Pages 1 and 2 Department of Heelth a importent: if item 27 is any injury or other trat once. MATTIE E. WATTS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ARBUTUS CEMETERY 01-07 -05 * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN TR, FUN JOSEPH H. TON AVE, BALTO. JR, FUNERAL HOME 21. Signature of uneral Service Licenses Down 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Que to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificete has b irector, page 2 s 22 No 1 Yes Hospitel or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ 2 ER/Outpatient 3 DOA this After this . Magner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending death. 1 Tyes investigation 2 Accident filled in by the f 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a), Shabbir State Registrar

State of Maryland / Department of Health and Mental Hygiene 41852 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death [□]3⁄1, 200/4 **Physician** Bessie Davis Williams December 8:20 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F 103 237-20-9794 March 28,1901 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 6105 Montrose Road 20852 United States ітетв 23а Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 2 3 X Widowed 4 ☐ Divorced natural Completed 16a, Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ified within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laundry Company 6th grade Laundry Presser permit. Pages 1 and 2 should be filed be partment of Heelth and Mental Hygic Important: If item 27 is marked other? any injury or other traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ellic Davis Mary (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Welch (Grand daughter) 7712 Old Sandy Spring Road; Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery Jan. 8,2005 Wilson, North Carolina 21. Signature of Funeral Service Ligensee W. Wesley Chavis III Funeral Services, Inc W. Wer 1722 North Capitol Street, N.W.; Wash.D.C. 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician oneumonia aspiration disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760. the attending physicien Physiclan/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy requires that the death in the past 12 months? ō Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown led Complet 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law has page 2 autopsy certificate 1 🗌 Yes 2 🗗 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours after To the Funerel Dire To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number C 10034726 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 6121 Mintrose Rd., Rockville, MD m . D. JASMINE 31. Date filed (Month, 32. Signature State

Registrar

Williams, walter

	Amend item#19b, perFh, G839, State of Maryland 1- For State Registrar	ack Indelible Ink. Ensure All 777 Department of Health and Me Certificate of Death	Copies Are Legible. ental Hygier 0 0 4 4 1853
Physician /Medical	1. Decedent's Name (First, Middle, Last) Walter Lee Williams		2. Date of Death Month Day Year DEC 21 2004 0915 AM
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) Sc. Ag rus Heath Care 5. Social Security Number 247-70-5710 1 □ XM 2 □ F 61	Yrs Months Days Hours Min.	4c. County of Death N/A B. Date of Birth (Month, Day, Year) Dec. 26,1942 S. Carolina
e Maryland a-1 show illing at		Town or Location Baltimore	10d. Inside City Limits ★★★
036 urs after death with the Malair, or items 23e or 28a-1 s Examiner must be mulified by Funeral Director	10e. Street and Number 2251 W. Baltimore Street	10f. Zip Code 21223	10g. Citizen of What Country? USA
ING 21215-0036 be filed within 72 hours after death with the Maryland tall Hygiene do other than "natural", or items 23e or 28e-1 show event, if a Modical Examiner must be notified at Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Speciff Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☑ No Specify:	fy Yes or No- can, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036 ed within 72 hours at yegne. yegner than "natural", or yegner than "natural", or yegner than "natural", or yegner Example than the month of the yegner than the yeg	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Drizzata Industru
E saby	Leonard Williams	Construction Worker 18. Mother's Name (i	First, Middle, Maiden Sumame) ldwin
Mar 12 s ris rau	Marjorie Williamd/ Wife	19b. Mailing Address (Street and Number or Rural F 25	Raltimore MD 21218
Baltimore, I pernit. Pages 1 and Department of Healt Important: If item 2; any injury or other 1 once.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lt., see	carmel Cemetery 12/2 Carmel Cemetery 12/2 22. Name and Address of Facility Chart 52.40 Reisterstown	7/04 Dundalk, Maryland
be executed be executed loss and loss and burial-transit and Examiner at Examiner	23a. Part 1 Inter the disease, or complications that caused the death. In shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause) Due to (or	Do not enter the mode of dying, such as cardiac or removed with brain metace of):	espiratory arrest, Approximate Interval Between
P.O. Box 6876 that the death certificate bed by the attending physic detached for use as the branch Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	ath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting \mathcal{H} \mathcal{V}	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
I Rec The law ate has b page 2 sl			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
~ × × × ×	25. Was case referred to medical examiner: 1 □ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 □ EPV	26. Place of Death (C Outpatient 3 DOA Other: 4 Nursing Home	Sheck only one) 5 Residence 6 Other (Specify)
ling Lune Tune			Describe how injury occurred
Division Hospitel or Attance 24 hours after death Funarat Director: etely filled in by the till dical Certificat	4 Homicide determined 288. Place of Injury - At home, building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
Diversities or within 24 hours after within 24 hours after to the Funarat Direct completely filled in I	29a. Certifier (Check only one) 2□ Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a 29c. License number	at the time, date and place, and due to the cause(s)
F % F 8	30. Name and address of person who completed cause of death (Item 23a	P18612	29d. Date signed (Month, Day, Year) DEC, 21, 2004
3 State	MUHAMMAD TALHA	M.D.	
Registrar DHMH 17 Rev 1/2001	31. Date filed (Month, Day, Year) JAN 0 4 2005	(parle)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician William Ρ. Wilkin December 27, 2004 12:20 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 12310 Rosslare Ridge Road #106 Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 6. Sex 5, Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Yrs. Director 361-10-0363 80 22, 1924 Illinois Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic evant, the Medical Exertition is the rightled at 1 ☐ Yes 2X No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 12310 Rosslare Ridge Road # 106 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛛 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Senior Electrical Engineer Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter J. Wilkin Dorothy Irene Wilkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Wilkin/Wife 12310 Rosslare Ridge Road # 106 Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dec. 31, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. John Church 4 ☐ Donation 5 ☐ Other (Specify) Hydes, MD Cemetery 22. Name and Address of Facility 21. Signature of Funeral S Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Inc. Flagle 23a. Part 1 St er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 12 minn **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No this certificate has 2 2 No 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After . 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Diractor: 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical Chack only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Chris D00 2250S 0

State Registrar

DHMH 17 Rev 1/2001

JAN 0 4 2005

Dr. H. Charles Kim M.D.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



7505 Oslar Dr. Suite 201 Towson, MD 21204

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiere 00 L 41855 Certificate of Death 2. Date of Death 3. Time of Death Month Year Charlotte Virginia Walters

Physician /Medical Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Health and Mental Hygiene. Important: if Item 271s marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Madical Examinar must be notified at anotes.

Baltimore, Maryland 21215-0036

Murlotte Walters

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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er	4a. Fecility Name (If not institution, g Makyland Ge	neral Hi	spital	- Dul	HM	ocation of D	Cit	ly	4c. Cou	nty of Dea	th			
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by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1	er in U.S.							Black, Whi	erican Indian, te, etc. white			
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lo Be C	17. Father's Name (First, Middle, La William	st)					Name (Fir Leona	st, Middle, M			57			
	19a. Informant's Name/Relationship Frank Heubeck	(Type, Print) (Son)		failing Address Manhat							Zip Code) MD 21146			
	20a. Method of Disposition X		20b. Place of D cemetery, Woodlaw	crematory or o	ther place,	1/	Date 3 /:			,	Town, State Maryland			
	21. Signal Funeral Service Lice	Curpenter	_	Burgee- 3631 Fa			tz Fu Balt	neral	Home,	Inc	21211			
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tification	1 Vatural 5 Pending 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	t be 28e. Place of Injury	(Month, Day Year) Injury 10 28e. Place of Injury - At home, farm, street				Work? M 1 ☐ Yes 2 ☐ No et, factory, office 28f. Location				ation (Street and Number or Rural Route Number,			
Medical Certification;	4 Homicide building, etc. '(Specify) City or Town, State) 29a. Certifier Check only one Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated and place.													
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon 12/30/04										th, Day, Year)			
	30. Name and address of person we mail R	a completed cause of dea	th (Item 23a) (Ty		RYI	land	Ge	nera	lx	1050	tal			
e ar	31. Date filed (Month, Day, Year)	2005 32 Tegistrar	s Signature	both						1				

State Registrar

			For Stata Registrar	State of M	aryland /			of Head		d Mental H	lygier		ł	41856						
			Decedent's Name (First, Middle, Last) Day							Dav	Year	3. Time of Death								
	Physicia /Medic		Mary S. Wallis				12					-	004	22:45 M						
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Н	Funeral		5. Social Security Number 6. Sex 2 15 - 30 - 6532 1□	M 2 F 7. AS	ge (In yrs. last 72	Vrs.	Months			Irs. 8. Date of (Month, Apr.	Day, Yea	ar)	Cou	place (State or Foreigr htry) WOLINA						
	Director		Usual Residence of Decedent		7 2					Apri.	30,1	732	N. C	wwwnu						
	yland yland		10a. State 10b. County		10c. City, To	own or Lo	cation		-					Od. Inside City Limits						
	a-f sl	ctor	Maryland Baltimore					more						1 ☐ Yes 2 XNo						
	or 28	Oire	10e. Street and Number	_			10f. Zip				10g.	Citizen of W		ntry?						
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36	l', or		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 If Yes, Give Year or Dates:	NO		1 ☐ Yes 2	K No S	Specify:			Specify:	Whi	0						
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Maryland	d 2 sh h and 7 is n traun		19a. Informant's Name/Relationship (Typ Mrs. Lynn Tardif	o, Print) (daught						Bural Boute Nu berdeen		2100	_	Code)						
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Baltimore,	t. Page rtment o rtant: If njury or		1 ☐XBurial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Garde		natory or ot		m 1/	3/2005	Ral	timan	0 1	laruland						
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	Sta		31. Date filed (Month, Day, Year) 4 20	32. Regist	trar's Signature	1	rester	8												
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () 4 1857 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** РМ Wanda Lee Wratchford DEC. 2004 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Towson Baltimore If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Hours 1 ☐ M 2 🔀 F 72 Yrs. Director 215-74-7129 DEC. 17, 1932 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Example must be notified at MD Baltimore Reisterstown 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 Ridge Lawn Road 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☒ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Gordon Wratchford Edith Mae Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene D. Wratchford - brother 1625 Bowleys Quarters Road, Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crm. 1/02/2005 Laurel, MD 21. Signature of Finaral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Avyngen(monthus disease or condition resulting in death) /Medical Due to (or as a constituence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ecuvent pheumonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \(\text{Homicide} \) 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 205205 December 30, 2004 hon 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) N. Charles St. Galts My 20201 6701 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 4 2005 Registrar

2554

December

J ratchford,

			1 State	of Maryland / [Department of He			2001.	1.1858			
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Octimicate of D		Reg. N 2. Date of Death	<u> </u>	3. Time of Death			
	Physicia /Medic		Gloria		Weber			29, 2004	11:30 P ^M			
	Examin		4a. Facility Name (If not institution, give street and n		4b. City, Town, or l		4	c. County of Deatl	1			
			Mays Chapel Ridge Assis 5. Social Security Number 6. Sex	ted Living 7. Age (In yrs. last bil	Luther		B. Date of Birth	Baltimo				
	Funeral Director		115-18-3046 1□ M 2♥F	78	Yrs. Months Days	Hours Min.	(Month, Day, Yea	1926 Ne	nplace (State or Foreign untry) WYORK			
	σ		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	To ar Legation				10d. Inside City Limits			
	faryla s to e	ō							1 Yes 2 No			
	the N	rect	Maryland Baltimore 10e. Street and Number	Lut	therville 10f. Zip Code		10g. (Citizen of What Co	untry?			
	th with	Funeral Director	121 Gothard Road		21093			U.S.A.				
	r dea	nner	Armed 8	cedent Ever in U.S. Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Amer Black, White				
36	rs afte	by Fi	1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Year or		1 ☐ Yes 2 ☐XNo	Specify:		Specify: Wi	nite			
21215-0036	72 hours effer death with the Maryland natural', or Itams 23a or 28a-1 show dical Examinar must be notified at		15. Decedent's Education (Specify only highest grade completed	16a	Decedent's Usual Occupat (Give kind of work done du	tion	16b.	Kind of Business/l				
215	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	life. DO NOT use retired)				E.3.			
	filed w Hygier other th		17. Father's Name (First, Middle, Last)	Cu	stomer Servi	Ce Rep. 18. Mother's Name		dustrial	Filters			
Maryland		To Be	Gustave Wuterich			Evelyn	Ada	Rose				
ary	2 should be and Mental Is marked a		19a. Informant's Name/Relationship (Type, Print)	196	o. Mailing Address (Street ar				ip Code)			
	and 2 ealth a m 27 ls			J	1 Gothard Roa		rville, M		21093			
lore	ges 1 a it of Hear If Item or othe		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Removal from	n State Dullan	f Disposition (Name of ry, crematory or other place, IEY Valley) Da	0005	Location - City or				
Baltimore,	permit. Pages: Department of H Important: If Its any Injury or ot		1 □ Donation 5 □ Other (Specify) 21. Signature Fine Service Licensee	Me	morial Garder	of Facility Ruck	3, 2005 C Towson	Ilmonium Funeral H	Maryland Home. Inc.			
Ba	Depar Impo any Ir		Hawan Haram		1050 York 1	Road To	wson, Mar	yland 212	204			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	Pnysician		Immediate Cause (Final disease or condition	VEUMONIA					Onset and Death 2 WEEKS			
	/Medical Examiner		resulting in death) Due to (or as a consequence of):									
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8760,	icate be executed physician and s the burial-transit		resulting in death) Last Due to									
687	ate hys	Physician/Medical	d									
Box (death certific e attending p id for use as f	n/Me	IF FEMALE: 23c. If yes, of the control of the contr	23d. Date of deli-	very							
	0 0	sicla	in the past 12 months? 1 Ves 2 No 4 Pres	birth 2 Fetal death gnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			Month	Day Year			
P.O.	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Dther significant conditions contributing to		n the undertying cause given	n in Part I	23e. Did tobacco	use contribute to	the cause of death?			
ds,	w requires that the s been signed by the should be detache	Completed by	ENDSTAGE DEMIENT	_			1 🗆 Yes	2 □ No 3 □ Pro	bably 4 Unknown			
Vital Records,	s beer s shou	olete					24a. Was an	24b. Were au	opsy findings available			
Re	The law ate has b page 2 sl	mo					autopsy performed?	death?	ompletion of cause of 2 \(\subseteq \text{No} \)			
/ita	Physiclen: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death			Assisted			
of	Phys this ral di	- To	1 Yes 2 No		utpatient 3 DOA Other	4 Nursing From	e 5 Residence		wLiving			
ion	Attending Phir death. sctor; After thi	ation	1 KNatural 5 ☐ Pending (Mo 2 ☐ Accident investigation		Injury Work?	es 2 🗆 No	200. Describe flow injury occurred					
Division of	I or Attendi after death. Diractor: A I in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place	ce of Injury - At home, fa ding, etc. (Specify)	arm, street, factory, office	28	Bf. Location (Street a	and Number or Ru	ral Route Number,			
	Hospital or 24 hours afte Funaral Dir tely filled in I											
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the (Check only one) 2 Medical Exeminer: On the and ma	ne best of my knowledge basis of examination ar nner stated.	e, death occurred at the time nd/or investigation, in my opin	nion, death occurred	d at the time, date a	nd place, and due	to the cause(s)			
	To the within 2. To the complet	Me	29b. Signature and title of certifier		29c. License	number		ate signed (Month	, Day, Year)			
)			In porte	Jun	000476	25		130/04				
	15		30. Name and address of person who completed ca	use of death (Item 23a)	(Type, Print) RICHAR	DO OMALLE	7170	4				
	Sta	te	31. Date filed (Month, Day, Year) 32.	Registrar's Signature		0. / 11/10	010	1				
	Registr		JAN V 4 2005 Kee	De It B	certi							

State of Maryland / Department of Health and Mental Hygien 2004 41859 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jamie Watford December 22, 2004 1030 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) (9. Birthplace (State or Foreign (Country) **Funeral** Days Hours Min -94-434 Months 1 X M 2 □ F Director ano Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Directo Nar y land 10e. Street and Number more 10f. Zip Code 10g. Citizen of What Country? or Items 23a or Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give/ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifq. DO NOT use retired) Elementary Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumaine) Be 19a. Informant's Name/Relationship (Type, Print) mot er ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If Ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility once. Home uzeral W. North 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition Brain death **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Brain hermiation 2 days Sequentially list conditions, riany, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of Examine burial-transit or Attending Physician: The law requires that the death certificate be executed Hy potension and (or as a consequence of): P.O. Box 68760 the attending physicien Physician/Medical ongestive heart years as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown yd bengis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 2 M No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat e Funerel Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 22 Susanna Mag PES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street MATSEN Baltimore, Manylan SUSANNA 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State **JAN 04** Registrar

DHMH 17 Rev 1/2001

Andre D. Wright Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-08254 crn 1- State of Maryland / Department of Health and Mental Hygiene Registrer

State of Maryland / Department of Health and Mental Hygiene C839 1-5-05 Las

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 10 <u>December</u> 2004 10:00A /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** E. 25th Street, Apartment 12K Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1**⊠**M 2□ F Days Hours 218-72-7356 Usual Residence of Decedent Director the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at Director 1 Ses 2 No Maryland Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 23e Funeral or flems Was Decedent Ever in U.S Armed Forces? ... 11. Marital Status 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 If Yes, Give Year or Dates: es 2 No Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: " 3 Widowed 4 Divorced Slac natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.

7 Is marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) ompanies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wria George 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Father item 27 l 20a. Method of Disposition-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite eny injury or of once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Home Enter the disease, or complications that caus or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Narcotic, cocaine and alcohol intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autoosy performed Yes 2□ No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Cther: 4 Nursing Home 5 Residence 6 Nother (Specify) At Scene ^o 1 XYes 2 ☐ No 28b. Time of unk 28c. Injury at Work? 28a. Date of Injury Found: Day Year) 27. Manner of Death Certification: 28d. Describe how injury occurred unk 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 No 2 Accident 12-22-04 6X Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Boute Number, City or Town, State) $\underline{401}\ E_{\:\raisebox{1pt}{\text{\circle*{1.5}}}} \, \underline{25th}\ St_{\:\raisebox{1pt}{\text{\circle*{1.5}}}}$ in by 4 - Homicide Baltimore, within 24 hours a Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Sign

Registrar

Day, Year) JAN 0 4 2005

of person who completed cause of

hath (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 23, 2004

			For Stata Registrar	State of Mar		partment of Hea ertificate of De			2004	41861
Ī	Physicia	an	1. Decedent's Name (First, Middle, La. Polly Mae Yelto	•				2. Date of Death Month Dec.	Day 2004	3. Time of Death 10:00 AM
-	/Medic Examin		4a. Facility Name (If not institution, give 14740 Schalk Ros	e street and number)		4b. City, Town, or Loc	cation of Death		4c. County of Dea	nth
	Funeral Director		5. Social Security Number 6. S		(In yrs. last birthda) If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	9 Bir	thplace (State or Foreign quintry) th Carolina
	ס		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	the Mary 28e-f sh	Director	Maryland Carrol	1	Millers	10f. Zip Code		100	g. Citizen of What C	1 □ Yes 2. No ountry?
	s 23a or		4740 Schalk Ro			21102	ania Origin? (Sno	oifu Vos or No-	U.S.A.	erican Indian
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show any njury or other treumetic event, the Medical Ever it with native multified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		I. Was Decedent of Hispa If Yes, specify Cuban, N 1 ☐ Yes 2 ☐ No S	Mexican, Puerto F	Rican, etc.)	Black, Whi	
Baltimore, Maryland 21215-0036	within 72 ho ane. than "netur e Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Giv	edent's Usual Occupation re kind of work done durin DO NOT use retired) LSewife	n ng most of workir		Bb. Kind of Business Homemak	,
and 5	d be filed v ental Hygie ced other i	To Be Co	17. Father's Name (First, Middle, Last, Criss Garland)				(First, Middle, Ma	iden Sumame)	
Mary	nd 2 shoul lith and Me 27 is marl r treumeti	F	19a. Informant's Name/Relationship (Donna Lang - dau			iling Address <i>(Street and</i> O Water Tank				
more,	Pages 1 a nent of Hes int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		20b. Place of Dis cometery, co Kirkrid	position (Name of ematory or other place) se Church Ce			Manchest	
Balti	permit. Departmitmporte any inju		21. Signature of Funeral Service Lice		1	Name and Address of Charmil	feral Ch	apel P.A	, Md. 211	02
ĺ	Pnysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the cause on each line		or the system of	uch as cardiac of		t.	Approximate Interval Between Onset and Death 3 months
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a	consequence of):	enosis	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			~
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to innite diate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	CONSCIONAL OF					5 years
,0928	cate be executed physician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a	consequence of):					,
.O. Box 68	The law requires that the death certificate be executed tae been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1∐Live birth 2 4∐Pregnant at ti 9∐Unknown	Fetal death	B⊟Ectopic pregnancy B⊟ Other (specify)			23d. Date of de Month	olivery Day Year
۵.	quires that in signed by all be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause given in	n Part I.	23e. Did toba 1 ☐ Yes		o the cause of death? robably 4 □Unknown
Vital Records,		Completed						24a. Was an autopsy performs	prior to	utopsy findings available completion of cause of
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes = 2 X No	Hospital: 1 ☐ Inpatient	t 2 ☐ ER/Outpat	Other		(Check only one)	ce 6 □Other (Spe	ecify)
on of	ding After fune	tion; T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28b. Time	Work?	2 □ No	8d. escribe how	injury occurred	
Division	i te	Certification;	3 Suicide 6 Could not be determined	e 28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, office	2	28f. Location (Stre City or Town,	et and Number or R State)	lural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) Certifying Plants (Check only one)	nysicien: To the best of niner: On the basis of e and manner state	examination and/or	ath occurred at the time, of investigation, in my opinion	date and place, a on, death occurre	ed at the time, date	e and place, and du	e to the cause(s)
}	To th To th	W	29b. Signature and title of certifier	ATTENDW	e physic	29c. License nu D 2	1155		I. Date signed (Mon	
	b		30. Name and address of person who ARTHUR L. RU	completed cause of dea	ath (Item 23a) (Type 04 WAS	e, Print)	RD W	ESTMIN	STER, M	D 21157
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Red Strar	's Signature	ALMOTON GOOD				

			riease	State of Maryland / [Department of Health and	=	_
			For State	State of Maryland / L	Certificate of Death	Reg. N	/11111 1.1969
			Registrer 1. Decedent's Name (First, Middle, Las	st) .	- CONTINUATE OF BOATS	2. Date of Death	3. Time of Peath
	Physicia /Medic Examin	al .	ELNA MALE 4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Location of Deat	127	ay Year M
	LAUIIIII		3600 Belle	Ave	Baltimore thday) If Under 1 Year If Under 24 Hrs		N/A
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs Yrs. Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country)
	and ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
	the Mary 28a-f sho	Director	10e. Street and Number	A	Baltimor.		1 No 2 No Sitizen of What Country?
	3a or		3/W Bolle	AVA	21215		USA
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. id other then "naturel", or items 23a or 28a-f show orbit. The Madical Examiner must be notified at event.	全	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	io 1 iio., 5(6.)	Specify: Black
5-0	"natu	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
121	within 72 ene. then "na he Mudic	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	Cosmetologist		Have
d 2	illed Hygie other	BeC	17. Father's Name (First, Middle, Last)			me (First, Middle, Maide	1 101.1
/lan		ToB	Thaddeus M	1c Donald	Edna	M_{00}	re
lar	d 2 should h and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship	Type, Print) 19b	. Mailing Address (Street and Number or Ru		
	s 1 and f Health item 27 other to		20a. Method of Disposition	11Ston/daugh 6	180 - Schusto HD	Date 200	Location - City r Town, State
ğ	00		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specific	Removal from State	ry, crematory or other place)	005 P	-Ha MD
Baltimore		1	21. Signatus Fureral Service Licen		22. Name and Address Tracility	E103 [un o ji no
ä	permit. Departr Importu any inj		1 Swood	harch	JT AM 1832 M	lievalley 1	Dr. Jesse PA18434
			23a. Part1 Enter the disease, or com shock or heart failure. List only	plications that caused the deeth. Do one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
	Physician	8	Immediate Cause (Final disease or condition	a I Purbable) 1	trute musicual	ul Infar	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):	111	11117
1		- a	Sequentially list conditions,	b. Due to (or as a consequence	4 butching 1	SU CH	15 VYG
V:1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			9,	
ó	te be ext cuted ysician and te burial transit		resulting in death) Last	Due to (or as a consequence	of):		
3760,	a × a	Ilcai	(d			
x 68	leath certificat attending phy I for use as the	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			
Вох	attenc for us	clan/	23b. Was decedent pregnant in the past 12 pronths?	1 Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	that the de led by the a detached t	ysic	1 ☐ Yes 22 No 9 ☐ Unknown	9☐ Unknown	o a causi (speedi))		
ď.	The law requires that the death certifica sie has been signed by the attending ph bage 2 should be delached for use as it	by PI	Part II. Other significant conditions of	ontributing to death but not resulting i	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
g	w require been sig should b	ted	Chrome.	Atripol Fibril	latan -	1 🗆 Yes	2 No 3 Probably 4 Unknown
Records,	lawr nas be s 2 sh	Completed	MUNISTRACIO	1		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			100	simer's rich	400	performed?	death? lo 1 Yes 2 No
Vital	Physicien: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	Others	ath (Check only one)	G [70]
of	- − €	7: To	1 ☐ Yes 2 No 27. Many of Death		Time of 28c. Injury at	dome 5 V Hesidence 28d. Describe how in	
io	Attending ir death. ector: After by the fune	atlo	1 √ Natural 5 ☐ Pending 2 ☐ Accident investication	1	Injury Work? M 1 ☐ Yes 2 ☐ No		
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Cover not b 4 ☐ Homicide deremined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Tempol	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier 12 Certifying Ph	ysician: To the best of my knowledge	e, death occurred at the time, date and place	e, and due to the cause	s) and manner as stated.
	the Ho in 24 the Fu	Medical	one)	niner: On the basis of examination ar and manner stated.	nd/or investigation, in my opinion, death occi		
	To To To I	2	29b. Signature indititle of certifier		29c. License number	29d. D	date signed (Month, Day, Year)
7			/ / Www	Num	Time Brief 718152		305
	3		30. Name and address of person who	Lanc Will A	od con a Chi	ato um	71001
	Sta	ate	31. Date filed (Month, Pay, Year)	32. Redistraits Signature	(1 15 ABBA)	IL ILAL IAD	11001
	Registi	rar	JANUS	2005 Reen &	South !		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienes 1 - Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 30,2004° **Physician** 3:20 PM M DOROTHY ANNE ASENDORF /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL CARROLL HOSPITAL CENTER WESTMINSTER Months Days Hours Min. APRIL 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months MARYLAND 1 M XX F 90 212-01-3264 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ent: if item 27 is marked other then "naturel", or Items 23a or 28a-f ehow ury or other fearmatic event. It he Medical Exam har the notified at ury or other fearmatic event. Its Medical Exam har must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XXes 2 □ No CARROLL MT. AIRY Completed by Funeral Director MARYLAND 10g. Citizen of What Country?
UNITED STATES 10e. Street and Number 10f. Zip Code 21771 813 MERRY GO ROUND WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SAVINGS & LOAN UNDERWRITER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNA SUCHTING WILLIAM ASENDORF ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
727 MULLER ROAD, WESTMINSTER, MD 21157 19a. Informant's Name/Relationship (Type, Print) CHARLES H. GARRETT/COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. CARROLL CREMATION 01/02/2005 HAMPSTEAD, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MYFRS-DURBORAW FUNERAL HOME, PA
91 WILLIS STREET, WESTMINSTER, 21. Signature of Funeral Service License 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OMB! /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Box 68760. as attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 🗆 Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant corplitions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4♥Unknown 2 🗌 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2 Was case refe examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2√No Inpatient P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA this 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide within 24 hours aft To the Funerel Di completely filled in 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MILE Jule completed cause of death (tem 23a) Type, Print) 30. Name and address 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of M		Departn		ealth and	Mental Hy	giene Reg. N2 0 0 4	41864
			Decedent's Name (First, Middle,	Last)					2. Date of De	ath	3. Time of Death
	Physicia /Medic				Allen				Decembe	r 19 2004	
	Examin		4a. Facility Name (If not institution,	give street and number))	4b.	City, Town, or	Location of Dea	ath	4c. County of Dea	ath
			Doctor's Hospi	tal			Lanhar			Prince	
	Funeral				ge (In yrs. last		Inder 1 Year nths Days	If Under 24 Hr Hours Mir		th iy, Year) 9. Bi	rthplace (State or Foreign Country)
	Director	-	223-88-3083 Usual Residence of Decedent	1□M 2□F	78	115.			March 3	3, 1926 Vi	<u>rginia</u>
	land		10a. State 10b. County		10c. City, To	wn or Locatio	n				10d. Inside City Limits
	Mary f sho	ō	VA Staffo	r.d	Chi	fford					1 Yes 2 No
	the 28a	Director	10e. Street and Number	1.0) SLa	afford	of. Zip Code			10g. Citizen of What C	Country?
	3a o	0 1	117 Coal Landi	ng Road		1	22554			USA	
	deati	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.			spanic Origin?	Specify Yes or No arto Rican, etc.)		
9	after or Its		1 ☐ Never Married 2 ☐ Marrie		No		es 257 No	Specify:	nto i nozii, oto.)	Specify:	ne, etc.
93	ural',	d by	3 ₩ Widowed 4 Divorced	Year or Dates:						В	lack
21215-0036	within 72 hours after death with the Maryland ene. Than "tratural", or Itams 23a or 28a-f show than "kedical Examiner must be notified at	Completed	15. Decedent' (Specify only highesi		10	(Give kind	Usual Occupa of work done d OT use retired.	turina most of w	orking	16b. Kind of Busines	s/Industry
12	withir tene. than	m	Elementary/Secondary (0-12)	College (1-4or	5+)	Dome	,	,		Home	
d 2	filed Hygie other		17. Father's Name (First, Middle, L	ast)		Dome	SCIC	18. Mother's N	ame (First, Middle	, Maiden Sumame)	
an	id be ental ked o	To Be	John C. Thomas					Beatri	ice Thoma	S	
Maryland	and Mental and Mental Is marked o	-	19a. Informant's Name/Relationsh	ip (Type, Print)	1	9b. Mailing Ad	dress (Street a			er, City or Town, State,	Zip Code)
	1 and 2 Health a am 27 Is ther tra		Garry Johnson	- Nephew		7003 N	ashvill	Le Rd. I	Lanham, M	ID	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at any injury or other traumatic avant, the Medical Examiner must be notified at ange.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Pamayal from State	dom.	of Disposition	(Name of y or other place	θ)	Date	20c. Location - City o	r Town, State
<u>m</u>	Pages nent of I ant: If it: ury or o		'4 □Donation 5 □ Other (Sp	ecify)		ford Me	em. Par	k 12/	27/04	Stafford,	VA
alt	permit. Pag Department Important: I any injury o		21. Signatur / Funeral Service L	icen ee	00	22. Nai Bāi	ne and Addres	s of Facility neral Se	rvice		
<u> </u>	20 = 20		Jack V	JOSUL		120	7 White	Street	Frederi	cksburg, V	Α
			23a. Parti. Enter the differse, or shock, or heart failure. List of	complications that cause only one cause on each I	d the death. Dine.	o not enter the	mode of dying	g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a Acu	He	Arru	ther	MIA			Onsor and Dodin
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	l				
١.		<u></u>	Sequentially list conditions,	b. Due to (or as	a consequence	e off:	POXII	4-			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			V					
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as	s a consequen	ce of):					
760,	eath certificate be executed attending physician and for use as the burial-transit	call	D	d							
89	tificat ng phy as th			1							
Вох	endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	e of pregnancy 2 D Fetal dea	ath 3⊡Ecto	pic pregnancy			23d. Date of de	,
	the att	Physiclan/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐Pregnant a 9☐ Unknown	at time of death		er (specify)			Month	Day Year
P.0	es that the digned by the be detached	Phy	Part II. Other significant conditio	ne contributing to dooth	but not regultin	a in the under	uina nauna aus	on in Bort I	23a Did t	obacco use contribute	to the cause of death?
S	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	l by	rait ii. Other significant conditio	na communing to death	Dut not resultin	g in the under-	ying cause give	on in Faith.	1 🗆		Probably 4 Unknown
Records,	w requir been si should	Completed							24a. Was	24h Word s	utopsy findings available
3ec	sician: The law certificate has t irector, page 2 s	mpl							auto	prior to death?	completion of cause of
a	n: Th ficate or, pa		OF Man area referred to modical					00.01 .60	1 Yes	2. No 1 □ Ye	s 2 No
Vital	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital:	ient 2□ER/	Outnationt 3	□ DOA Othe	201	eath (Check only of	dence 6 ☐Other (Sp.	acifu)
ō	g Physer this eral di		27. Manner of Death	28a. Date of Inj (Month, Da		. Time of	28c. Injury Work			how injury occurred	eony)
ion	Attending F r death. actor: After by the funera	atlo	1 Natural 5 Pending 2 Accident investig		ay rear/	Injury N		Yes 2□No			
Division	I or Attendi after death, Diractor: A I in by the fu	Certification;	3 Suicide 6 Could n	inca 286. Place of Ir	njury - At home atc. (Specify)	farm, street, f	actory, office		28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	ital or rs aft al Dii										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical I	g Physician: To the besi Examiner: On the basis	of examination	dge, death occ and/or investig	urred at the tim	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	is stated. ie to the cause(s)
	tha I	Med	one) 29b. Signature and into of certifier	and manner s	tated.		29c. License	number		29d. Date signed (Mor	oth Day Year)
	F S F S		200. Signature and little of Certifier	15.	0.11		7-	22000	2	17/10	1 JANI
6	11		30. Name and addless of person	no completed cause of	death (Itam 22	a) (Type Print	レジ	22.00	_>	141	11 court
18) (30. Name and addless of person	Horld cause of	10	A It	Lawel	md 20	707	•	
	Şta	ate	31. Date filed (Month, Day, Year)		trar's Signature						
	Regist		JAN 0 S	5 2005	see &	See	W				

			For State Registrar	State of Marylan		irtment of tificate of		and Me		giene 0	04	41865
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Wilso	_					Date of Dea Month	Day	Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give structure) Franklin Square 5. Social Security Number 6. See	Hospital Cen		4b. City, Town, Rose of If Under 1 Year	ale		. Date of Birt	Balt	imi	
	Funeral Director			M 2□F 72	Yrs.	Months Days		Min.	(Month, Da)	y, Year) 1932		place (State or Foreign htry) rginia
	ith the Maryland or 28a-f show	Director	10a. State 10b. County	10c. Cit	y, Town or Lo	10f. Zip Code		Midd1	e Rive	er 10g. Citizen of V		10d. Inside City Limits 1 ☐ Yes 2 No
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23e or 28e-f show injury or other traumatic event, the Marylan Examiner must be notified at high or other traumatic.	by Funerai	119 Glider Dr: 11. Marital Status 1 Never Married 2 Married 33 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade	12. Was Decedent Ever in U. Armed Forces? 1 GYes 2 No Kor 1f 78s, Give Year or Dates: 1950-cation	ean 1	Vas Decedent of Yes, specify Cut □ Yes 2 🖫 No	Specify:	gin? (Specit , Puerto Ric		Unite 14. Rac Blac Specify 16b. Kind of Bu	e - Americ k, White,	en Indian, etc. White
	be filed within ital Hygiene. Ital distriction of the them " event, I've Max	Be Compieted	Elementary/Secondary (0-12) 11 Years 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		kind of work done OO NOT use retire ICK Driv	er			Truc	king	
Maryland	d 2 should be the and Mental 7 is marked of traumatic ever	To E	Wilson L. Alsup 19a. Informant's Name/Relationship (Ty) Thomas Alsup / Son			g Address <i>(Str</i> ee	t and Number	r or Rural P		r, City or Town,		Code)
Baltimore, I	Pages 1 and 2 nent of Health ant: If item 27 Is ary or other tra		20a. Method of Disposition 1 Suburial 2 Cremation 3 R 1 Donation 5 Other (Specify)	emoval from State	lace of Disposemetery, crem	sition (Name of natory or other pla	ace)	Date	9	20c. Location -	City or To	
■ Balt	permit. Pages Department of Important: If i any Injury or once.		21. Strature of Funeral Service License 23a: Part1. Enter the disease, or compli	Masse	y	Name and Address PRuc 7922 Wis	k Funé e Ave.	ral H Dun	dalk,	Dundal Marylan	.k, I:	
	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	tabo	olic ac						Interval Between Onset and Death
68760,	ificate be executed pphysician and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of): Shock	ai lure						
Вох	:= C0 mi	Physician/Med	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnand Other (specify)	y			23d. Date Mor	e of delive	ory Day Year
ords, P	equires that sen signed b ould be deta		Part II. Other significant conditions con respiratory fail	tributing to death but not resu ure, clostr					23e. Did to	17		e cause of death?
al Rec	n: The law i ficate has bo n, page 2 sh	Completed by	or Western to the second							sy p med? d 200 No 1	rior to con eath?	osy findings available inpletion of cause of
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death cert within 24 hours after dear this certificate has been signed by the attending To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use it	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 🗌 i 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju Wo	ner: 4 Nur:	sing Home		ne) ence 6 ⊡Othe ow injury occurre		")
Divis	Ital or Attendi irs after death. ral Director: A led in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	') 				City or Town			
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the ti estigation, in my of	opinion, death	place, and	at the time, d	ate and place, a	nd due to	the cause(s)
,	()	_	30. Name and address of person who con	77000	η. D .	Ros	000	0	T	Decemb		31, 2004
	Sta Registr	4 16		(SON, 9000 Fro	anklin	Sauan	e Dr	Balt	imore	mD	519	37

Alsop, Wilson

State

31. Date filed (Month, Day, Year)

JAN 0 5 2005

30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

(ADD ALL ALL AMERICAN STREET, BALTIMORE, MARYLAND 21201

unud

32/Registrar's Signature

O.C.M.E

DEC. 12, 2004

			For State Registrar	State of	Marylar		artment of rtificate o			lental Hyg	iene 0	04	41867
			Decedent's Name (First, Middle,	Last)						2. Date of Deat	h		3. Time of Death
	Physici /Medic		Lisa Ann Bernhar	dt-Karls	son					Decembe	r 25, 2	2004	9:55 P M
4.	Examin		4a. Facility Name (If not institution,				4b. City, Town		ion of Death		4c. County		
			Montgomery Gener				01ne	•			Montg		
	Funeral Director		213-64-4981	3. Sex 1 □ M 2 □ F	7. Age (In yrs.	1 Ast birthday) 1 7 Yrs.	If Under 1 Ye Months Da		nder 24 Hrs. Irs Min.	8. Date of Birth (Month, Day Aug • 18	Year)	9. Birthp Cour Mary	place (State or Foreign ntry) Land
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	10d. Inside City Limits
	Mary f sho	ţo	Maryland Montgom	erv	Olr	iev							Yes 2 □ No
	r 28a	rec	10e. Street and Number		1011	10)	10f. Zip Cod	Θ		1	0g. Citizen of \	What Cou	ntry?
	h will	a D	17704 Swan Theat	er Court			208	32			US	3A	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic evant, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dece Armed For d 1 Tes If Yes, Giv. Year or Da	ces? 2∭No e		Was Decedent of Yes, specify C	uban, Mex	cican, Puerto	ecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. White
Ö	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usual Oc	cupation		/a-	16b. Kind of B	usiness/In	dustry
218	thin 7 e.	npie	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work do DO NOT use re	ne during r tired)	most or work	ing			
	ed with ygiene. ner thar	Con		4 Yrs.		Homem	aker					vn Ho	me
ind	should be filed wand Mental Hygies marked other tumatic evant, In	Be	17. Father's Name (First, Middle, La	•						e (First, Middle, I	Maiden Suman	10)	
중	should and Meni	ို	Frederick Bernha 19a. Informant's Name/Relationship			10h Mailie	- Add (Ca-		Thors	al Route Number	City of Town	Canan Ti	- Code)
Maryland	and 2 sho ealth and n 27 Is ma	1	Eric Benny Karls		ıse					rt Olney			(2008)
re,	of Health item 27 othar tra		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of natory or other	place)	1 0	Date	20c. Location -	City or To	own, State
Ë	Page nent c nnt: If		1 XBurial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe		Siale _	lean Me	m. Gard	ens			Olney,		
Baltimore,	permit. Pages. Department of Himportent: If ite any injury or of once.		21. Signature of Funeral Service Li	censee	,					nes-Rina			Home , MD 20904
			23a. Part1. Enter the disease, or c	omplications that cr	aused the dea						-		Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final	20,000,000									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. LUNG Due to (or as a conse	cINOM guence of):	[4						2H THOM
ŀ	Examiner					,							
	Ć⊓ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						1.0	
16	acute ind trans	ami	that initiated events resulting in death) Last	c									
8760,	cate be executed physician and the burial-transit	dical Examiner	resulting in Ceatify Last	Due to (or as a consec	quence of):							
87	cate l physic	dice	•	d									
Box 6	that the death certifued by the attending properties as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	4□Pregna	rth 2 ☐ Feta ant at time of a	al death 3	Ectopic pregna Other (specify				23d. Dai Mo	te of delive	ery Day Year
P.O.		hys	9 Unknown	9□ Unkno	wn					-			
Ś	g p	by F	Part II. Other significant condition	s contributing to de	ath but not re	sulting in the u	nderlying cause	given in Pa	art I.				ne cause of death?
ord	w requir been si should I		DIABETES MELL	נטדו.						1 ☐ Ye	s 2 No	3 Prob	pably 4 AUnknown
Record	law I	Completed								24a. Was a autops	24b. \	Nere auto	psy findings available mpletion of cause of
	: The law cate has	Con				···-				perform	No 1		2 No NIA
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: . 🔀 .				Othor		Check only on			
of	Phys this al di	10	1 Yes 25 No 27. Manner of Death	28a. Date o	·	28b. Time of	IL SELDON	4_		me 5 Reside			y)
O	ding h. After fune	tion	1 Natural 5 Pending	(Monti	h, Day Year)	Injury		njury at Work? Yes 2		20d. Describe no	w injury occurr	90	
Division	Attanding or death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could no	ot be	of Injury - At h	nome, farm, str	eet, factory, offi			28f. Location (St.	reet and Numb	er or Rura	Il Route Number,
á	at or s after	Certification;	4 Homicide	buildir	ng, etc. (Speci	ify)				City or Town	, State)		
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	(Check only 2 Medical E:	Physician: To the xeminer: On the ba	sis of examina	owledge, death ation and/or in	n occurred at the	e time, date ny opinion,	e and place, death occurr	and due to the ca	iuse(s) and ma	nner as st	tated. the cause(s)
	thin 2 the o the	Med	one) 29b. Signature and title of certifier	and mann	er stated.		29c. Lic	ense numb	per	25	d. Date signed	d (Month.	Day, Year)
}	7 × 5		Dr. Lilyre He.		. 0			58542			CEMBER		
			30. Name and address of person w			m 23a) (Tune		0274	•	90			
	12		DZ. LIBUSE HEINZ-1					UE #	515, W	HEATON,	M. D 20	1902	
	Sta		31. Date filed (Month, Day, Year)			ature							
	Registr	ar	JAN 0 5	לטטט י	Som	A A	MAN TO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item/18, 19a, perFH, C840, 2, 15, 05, TT.

Amend Items 4a, 186a, 244a, years Treparity of The Amend Items 4a, 186a, years Treparity of The Amend Items 4a, 186a, years Treparity of The Amend Items 4a, 186a, years Treparity of The Amend Items 4a, 186a, years Treparity of The Amend Items 4a, 186a, years Treparity of The Amend Items 4a, years Treparity of The Amend Items 4a, years Treparity of The Amend Items 4a, years Treparity of Th Certificate of Death 2. Date of Death 12/18/2004 1. Decedent's Name (First, Middle, Last) **Physician** Randon /Medical 4a. Facility Name (If notingtitution 4c. County of Death 4b. City, Town, or Location of Death give street and number) Scala Avenue Examiner Be Himone md. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🛛 F 10/06/1950 Director 214-62-5509 54 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 28a-f show Exacting must be notified at 1 XYes 2 No Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10 Itama 23a 2316 Ocala Avenue 21215 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural', or 1 ☐ Yes 2**X** No Black Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Assistant event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then. Elementary/Secondary (0-12) College (1-4or 5+) Assistant f Health and Mental Hygiene. Administrative Assistand Social Security Adms. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther Carter Elnora Carter Henry Brandon 2 19a. Informant's Name/Relationship (Type, Print)
E Brandon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2316 Ocala Avenue, Baltimore, Maryland 21215 Esther Carter/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

1. She ature of Funeral Serves License n Cemetery 12/23/2004 Landsdowne, Maryland
22 Name and Address of FacilityThe Derrick C. Jones F/H, P.A. Zion Cemetery 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause be each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) detached O signed by ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, page 2 should be 3 Probably 4 Unknown 2 X No Be Completed 1 Tyes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2X No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 The John 3 DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 □ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Contifying Physician; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only Medi 29c. License number 29d. Date signed (Mon)h, Day Year) 29b. Signature a nd title of certifier 1000576 0 30. Name in address of person who completed cause of death (Item 23a) (Type, Print) Marc Lowen, M.D., 25 Hooks Lane, Suite 212, Pikesville, MD 21208 39. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar IAN 05

		•	1- For Amend Items 24a, 26 per verb. Department of Health and Registrar Certificate of Death	Mental Hyg	ilene 2004 41869
			Decedent's Name (First, Middle, Last)	2. Date of Deat	th 3. Time of Death
	Physici /Medio		DONALD. W. BROWN	Month	Day Year 140AM
}	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	th	4c. County of Death
			Springfield Hospital Center Sykesville		CARROLL.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		
	Director		216-34-3932 107M 2 F 68 _Yrs. Months Days Hours Min.	6-17	-36 Unknown
	P .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		
	anyla shov	_			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f	ecto	MD Carroll Sykesville		Λ
	vith th	by Funeral Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Country?
	ath v	ral	Springfield Hospital Center 21784		USA
	er de Item	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s aff	Ϋ́F	1 Never Married 2		Specify: White
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show disal Exantres must be rodified at	edi	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
215	in 72 in " r	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life, DO NOT use retired)	rking	Tob. All of Sushibastingustry
212	with lene.	L L	Elementary/Secondary (0-12) College (1-4or 5+) Unknown		Unknown
	filed Hyg other ent,	Be C		me (First, Middle, M	Maiden Sumame)
an	id be entai ked ked	To B	Unknown Unknow	vn	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other treumetic event, I'm Wedical Exam are must be notified at	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ural Route Number	, City or Town, State, Zip Code)
Ž	nd 2 uith a 27 ls r treu		Medical Records, Springfield HC Springfield Hospital	Center,	Sykesville, MD 21784
ē,	s 1 a f Hea f Hea f Hea othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
E C	Pages ent of nt: If II		1 \ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify) \ \ Meadowridge Mem. Park 12/	/30/04	Elkridge, MD
altimore,	permit. Pages Department of Important: If II any Injury or o	li			
ä	Depa Impo any I		21. Signature of Funeral Service Licensee Buan A. Haugt HOM Sykesville, MD 217	1E & CHAP. 184 (410)	EL, PA (BOX 195) -795-1400
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final	uf.	Onset and Death
7	/Medical		disease or condition resulting in death) a. — Due to (or as a consequence 1):	201	
В	Examiner				
3	HENNE	Je.	Sequentially list conditions, If the leading to immediate Due to for as a consequence of the consequence of		
>	cuted nd ransii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		
0,	be executed sicien and burial-transit		resulting in death) Last Due to (or as a consequence of):		
8760,	certificate be executed iding physicien and ise as the burial-transit	Physician/Medical	d		
9	ntifica ng ph	Med	IF FEMALE:		
Вох		an/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery
	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	SICI	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
P.0	at the	Phy	9 Unknown		
	res that signed to be det		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to the cause of death?
ord	w requir been si should I	ted	Denigh trostate trypestrophy	I L YE	es 2 No 3 Probably 4 Unknown
ec	law las b	Completed by	Constipation	24a. Was ar autops	v prior to completion of cause of
H	i ician: The lav certificate has rector, page 2	Son	V	perform	ned? death? 2 ☑ No 1 ☐ Yes 2 ☐ No
/ita	clan: ertific	Be	exampler?	ath (Check only one	8)
)	shysia this c	70		ome 5 Reside	nce 6 Outer (Specify) (Clubs of Ca
ū	ding P h. After I funera	on:	27. Manner of Death 28a. Date of Injury 28b. Time of 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury Work?	28d. Describe ho	w injury occurred O was
sio	Attending Physician: r death. ector: After this certific by the funeral director,	catl	2 Accident investigation M 1 Yes 2 No		
Division of Vital Records,	or At fter d jirect n by	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
	urs a urs a sral [ပိ			
	Hos 24 ho Fun fely f	lica	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the ca urred at the time, da	tuse(s) and manner as stated. ate and place, and due to the cause(s)
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29b. Signature and title of certifier 29c. License number	29	3d. Date signed (Month, Day, Year)
	F ≱ F 8		TM20512		2/20/00
	f		20 Name and address of agrees who completed gauge of death (from 22a) (Time Brigh)	, ,	777107.
1	d		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	665	- Sitoevillo Rol
	Sta	to	31. Date filed (Month, Day, Year) 32. Registrar's Signature	_ 000	2000
	Registr		31. Date filed (Month, Day, Year) AN 0 5 2005 (32. Registrar's Signature)		ogcasoull
					1 170/

			1 - For State Registrar	of Maryland / Dep <i>Ce</i>	artment of F		ental Hygier	2001	41870
	Physici	an	Decedent's Name (First, Middle, Last)	DUGGE			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	ANN ELIZABETH BAI 4a. Facility Name (If not institution, give street and n		4b. City. Town, o	r Location of Death		30, 200 4c. County of Death	4 11:55%pr
	Exami	ei	STELLA MARIS HOSP1			MONIUM		BALTIMOR	RE
	Funeral Director		5. Social Security Number 219-30-1624 6. Sex 1 □ M 3\(\)	7. Age (In yrs. last birthday, 69 Yrs.	Months Days	Hours Min. N	3. Date of Birth OV • 1 4 • I	9. Birthp	place (State or Foreign htry) LAND
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			1	0d. Inside City Limits
	a-f sh	stor	MD BALTIMORE	HAMPSTI	EAD				1 ☐ Yes 2 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 4922 BLACK ROCK F	ROAD	10f. Zip Code 21	074		Citizen of What Cour	ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or Items 23e or 28e-f show appring yor other treumatic event, the Madical Examiner, until be notified at once.	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Wwidowed 4 Divorced 12. Was December 1 Personal Status	2. ⚠ No ive	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spec an, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
21215-0036	d within 72 ho giene. Ir then "netu	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(Give (1-40r 5+)	dent's Usual Occup e kind of work done DO NOT use retired OMEMAKER	during most of working d)	16b.	Kind of Business/Ind	,
Maryland	should be filed nd Mental Hygi marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) MICHAEL PATRICK COS				UISE BE	NNETT	
	and 2 sho lealth and m 27 Is mu			ighter 934	GAMING	SQUARE,	HAMPSTE	AD, MD.	21074
Baltimore,	Pages 1 tment of H tant: If ite jury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)		RTDGE		/2005 P	Location - City or To	E, MD.
Ba	permit Depar Impor any in		21. Signature of Edmeral Service Ligensee	5	16924 Y	ss of Facility HEN	MONKTO		111
	Prrysician /Medical Examiner	J.	Due to Sequentially list conditions. b.	caused the death. Do not eneach line. REAST CANCE! (or as a consequence of): (or as a consequence of):		g, such as cardiac or i	espiratory arrest,		Approximate Interval Between Onset and Death
38760,	icate be executed physician and s the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Die tabe of Injery) that initiated events c.	(or as a consequence of):					- 1946 M
.O. Box 6	t the death certif by the attending ached for use a	Physician/Medi	in the past 12 months?	nant at time of death 5	⊒Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year
rds, P.	w requires that been signed should be det	by	Part II. Other significant conditions contributing to d	death but not resulting in the u	nderlying cause give	en in Part I.		use contribute to the	
Vital Records,		Completed					24a. Was an autopsy performed?	prior to con death?	osy findings available apletion of cause of
Division of Vita	Attending Physicien: r death. ector: After this certific by the funeral director.	atlon: To Be		Inpatient 2 EP/Outpatier of Injury 28b. Time o Injury	f 28c. Injury Work	4 Nursing Home		6X Other (Specify, ury occurred	HOSPICE
-	- 0	Certification;	3 Suicide 6 Could not be determined 28e. Plac build	e of Injury - At home, farm, str ing, etc. (Specify)	reet, factory, office	28	Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical		e best of my knowledge, deatleasis of examination and/or in their stated.	vestigation, in my op	pinion, death occurred	d due to the cause(at the time, date ar	s) and manner as stand place, and due to	ated. the cause(s)
	To To Con	Σ	29b. Signature and title of certifier		29c. License	3725	29d. D	ate signed (Month, D	Day, Year)
1	77		30. Name and address of person who completed cau DR • TARIO MAHMOOD	se of death (Item 23a) (Type, 2300 DULANE		V DD m+	MONITING	MD 2100	2
	Sta Registra		31. Date filed (Month, Day, Year) 324	Registrar's Signature		I KD. TT	MONIUM,	MD 2109	3

State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
December 31, **Physician** WINIFRED TERESA BALDWIN 7:30 p M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 6034 Ciprano Road Prince George's Lanham If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 🕅 F Director 92 March 14, 1912 Washington, DO 577-18-0040 Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 10h County 28a-f show other treumatic event, the Mudical Examiner aust be nutfled at 1 ☐ Yes 2 X No Director <u>Maryland</u> Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 or Items 23a 6034 Ciprano Road 20706 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "naturel", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Washington Suburban Elementary/Secondary (0-12) College (1-4or 5+) Sanitary Commission Keypunch 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Paris Sarah_Elizabeth_Suit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is rr any Injury or other treurr <u>once</u>. E. Mae Trott - Sister 540 Bonnie Drive, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial /2 □ Cremation 3 □ Removal from State 1/5/2005 Cedar Hill Cemetery * 4 □Donation | 5 □ Other (Specify) Suitland, Maryland 21. Signal re of Funeral Se Vice Greenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MYOCARDIAL INFARCTION Las HOUSE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 X No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Statement 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After the Hospitel or Attending Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M- S Jan 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SANKARAN 38+WAVE BRENTWOOD, Md. NAYAR 3717 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar IAN 0 5 2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Z Year mar 200 4b. City, Town, or Locetion of Death Name (If not institution, give street and number) 4c. County of Death 586 lalbo YILLWOC If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 1 □ M 2 □ F 217-36-2370 1940 Feb 6, Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town,or Location 1 ₽YES 2 No ASTON 21100 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number RIUS USA 60 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑AYes 2 ☐ No If Yes, Give Year or Dates: 158— 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: white **'**58-62 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self employed Sumame) or Town, State, Zip Code) 37067 ocation - City or Town, State

Physician /Medical

Physician

/Medical

Examiner

10a. State

Funeral Director

δ

mpleted

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show

Baltimore, Maryland 21215-0020

ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at

Examiner

ettending physician end I for use as the burial-transit page 2 should be detached Certification: To

20 No

5 Pending investigation

6 Could not be determined

a

1 🗌 Yes

27. Manner of Death

1 Avatural

2 Accident

3 Suicide

29a. Certifier (Check only one)

29b. Signature

4 Homicide

or Attending Physician: The law requires that the death certificate be executed

been signed by the

within 24 hours efter death.

To the Funeral Director: After this certificete

To the Hospital

completely filled in by

Medical

Division of Vital Records, P.O. Box 68760

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BeC	17. Father's Name (First, Middle, Las	st)		18	. Mother's Nar	ne (First, Middle,	Maiden Surnar	ne)					
ToB	Theodore Ernes	t Bachman			Claudia	a Marsha	11						
_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Add	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Jenny Bachman/d	aughter	112 Eag1	es Glen	Drive	Frankli	n, TN	37067					
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☒ Donation 5 ☐ Other (Spec	☐Removal from State	Place of Disposition (cemetery, crematory			Date	20c. Location	- City or Town, State					
	21. Signature of Funeral Service Lice RONALO S	wade, Direct	or State	and Address of Anaton	-		Baltin	ore Street					
	Xman/11	Mul	Balti	more, M	D 212	01							
-	23a Part1. Enter the disease, or con Ishock, or heart failure. List onl	mplications that caused the de y one cause on each line.	eath. Do not enter the r	node of dying, s	uch as cardiad	or respiratory a	rrest,	Approximate Interval Bet Onset and I					
	Immediate Cause (Final disease or condition resulting in death)		Cor as a consequence		9 Co	mce-	•	Jan 2					
Examiner		b											
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequence	of):									
dical	Cause (Disease or injury that initiated events resulting in death) Last	cDue to	(or as a consequence	of):									
M/Me		I d											
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eleted by							an autopsy rmed?	24b. Were autopsy f available prior to completion of co of death?					
Som						101	166 2 3 TW	1 ☐ Yes 2 ☐					
Be	25. Was case referred to medical			26	B. Place of Dea	ath (Check only o	nne)	Hers					

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

3□ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ause of death (Item 23e) (Type, Print)

Registrar's Signature

Injury

28c. Injury at Work?

1 ☐ Yes

2 No

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Morgth, Day, Year) 2160

Other: 4 Nursing Home 5 Residence 6 Pother (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Approximate Interval Between Onset and Death

Jan 2004

use contribute to the cause of death?

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar SAN BIACKMON

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			For State Registrar		State of M	aryland		e <i>rtificate o</i>		nd Mental	Hygier Reg. I	2004	41873
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	th with the N 23a or 28a-1	al Director	10e. Street and Nu	L	9	Darri	llibre	County 10f. Zip Code 21206)	77		Citizen of What Co	
9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Exam par must be notified at	by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ied 2 ∑Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 IT If Yes, Give Year or Dates:		13	. Was Decedent of If Yes, specify Control of Yes 2 No.		n? (Specify Yes of Puerto Rican, etc	or No-	14. Race - Ame Black, Whit Specify: W	
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	1 and 2 sho Health and Sm 27 Is ma		19a. Informant's No. Scott R Bl 20a. Method of Dis		Type, Print)		7115	ling Address (Streenwood position (Name of		Baltimore,	Md. 2		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☐ Burial 2 4 ☐ Donation	'	·	cem	o Ocer	ematory or other p natory Dece 22. Name and Ado Lassah	ember 30 interest of Facility n. Funeral	. Hame Inc	Bal	timore, Ma	aryland
68760,	Physician and Medical Examiner	dical Examiner	23a. Part1. Enter to shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death) in the shock of the condition of the condition of the cause (Disease or that initiated events resulting in death) in the cause (Disease or that initiated events resulting in death) in the cause (Disease or the cause of t	in failure. List only (Final on on one of the one of th	Due to (or as Due to (or as d. d.	a consequer	nce of:	id Ho	e moRi	Rhage Whage		ARTERY	Approximate Interval Between Onset and Death Office
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Vital Records,	n: The law r ficate has be rr, page 2 sh	Completed								1 Y		prior to death?	utopsy findings available completion of cause of 2 No
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	Sta Registr		Dr. Stu 31. Date filed (Mon	vart W	completed cause of d	eath (Item 23	3a) (Type	MIN Sq	yare To	Drive, P	alti	mace, M	D. 21237

	-	For State Registrar	State of	f Marylar		artment of <i>rtificate o</i> a		nd Mental H	ygiene Reg. No	2004 WIN1
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kamine		4a. Facility Name (If not instituti 3800 Block New	gate Avenu	e		4b. City, Town, Balt	imore			County of Death
neral ector		5. Social Security Number N/A Usual Residence of Decedent	6. Sex 15€ M 2 ☐ F	7. Age (In yrs. 52	Yrs.	Months Day		8. Date of E (Month, I	Day, Year) 1952	9. Birthplace (State or Fore Country) Cabatuan Iloilo
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9 2	Completed							24a. Wa aut per 1 □ Yes	opsy formed2	24b. Were autopsy findings availal prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
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a .			tigation	of Injury h, Day Year)	28b. Time of Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe		
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letely fill	edical	29a. Certifier 1 Certify (Check only one) 1 Medice	ing Physicien: To the of Examiner: On the ba and mann	isis of examina	wledge, death tion and/or in	n occurred at the vestigation, in my	time, date and opinion, death	place, and due to the occurred at the time	e cause(s) , date and	and manner as stated. I place, and due to the cause(s)
0 1		29b. Signature and little of certifi	iAr /	1/1					20d Dat	e signed (Month, Day, Year)
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			For State Registrar	State of Maryl	land / Depa		lealth and M	lental Hygie		41875
	Physici	an	Decedent's Name (First, Middle, Last, Alice	J.		Clemmons		2. Date of Death Month DECEMBE	Day Year	3. Time of Death 4 1833 M
	/Medic Examin		4a. Facility Name (If not institution, give Union Memorial	street and number) . Hospital			Location of Death		4c. County of Dea	
	Funeral Director		240-84-8214	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 11–27–	9. Bir 47	thplace (State or Foreign ountry) N.C.
	Aaryiand I show	or	Usual Residence of Decedent 10a. State 10b. County Md . NA	100	c. City, Town or Lo					10d. Inside City Limits Y Yes 2 No
	with the N a or 28a- be notifi	Direct	10e. Street and Number 1600 E. 29th Str		-	10f. Zip Code	1218	10g	. Citizen of What C	ountry?
36	be filed within 72 hours after death with the Maryland Hygiene. id althygiene. or items 23e or 28e-f show or other than "natural", or items 23e or 28e-f show event. The Marie Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2X No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
Maryland 21215-0036	within 72 hou me, than "natural	Completed I	15. Decedent's Edu (Specify only highest grad	cation	(Give	dent's Usual Occup kind of work done DO NOT use retired achine Ope	during most of work d)	ring	b. Kind of Business Beverage	·
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lore,	ges 1 and 3 it of Health if item 27 or other tr		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 0	Removal from State	0b. Place of Dispo cemetery, cre	osition (Name of matory or other plan	17/200	Date 20	c. Location - City of	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other <u>00058</u> .		21. Signature of Funeral Service Licens			2. Name and Addre	ss of Facility	Balt	imore, Mo North Av	3. 21202
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the ne cause on each line.	death. Do not en	ter the mode of dyir				Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Pue to (or as a co	nsequence of):					1 Hour 24 DAYS
760,	te be executed ysician and e burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. MET 5 1 Due to (or as a co	ATIC	UTER	NE SA	RComi	9	24 DAYS
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Vital	Physician: this certificated ral director, I	o Be (25. Was case referred to medical examiner?	Hospital:	2 ☐ ER/Outpatie	ent 3 DOA		th (Check only one)	ce 6 ☐ Other (Sp	ecify)
ion of		-	27. Manner of Death 1	28a. Date of Injury (Month, Day Ye	28b. Time	of 28c. Inju		28d. Describe how	injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S		treet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
	e Hospi 24 hour e Funer etely fill	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or i	ath occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner a e and place, and du	as stated. ue to the cause(s)
)	To the within To the	Me	29b. Signature and title of certifier	Beleller	m	29c. Licen	se number	290 L	1. Date signed (Mor	TUNCKE, IND
6	1		30. Name and address of person who	completed cause of death	h (Item 23a) (Type	a, Print)	WRIAL	HOSPITE	AL BALT	inche ind
1	St Regis	ate rar	31. Date filed (Month, Din Mari) 5	2005 ^{32. Redistrar's}	Signature	porte				<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004

1. Decedent's Name (First, Middle, Last)

Certificate of Death

Physician	
/Medical	
Examiner	

Funeral Director

with the Maryland en "neturel", or Items 23a or 28a-f ehov Medical Examiner must be notified at filed within 72 hours after death Pages 1 and 2 should be ment of Health and Mental permit. Pages 1 and 2 s
Department of Health an
Importent: If item 27 is.
any injury or other treu 99

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> attending physician and for use as the burial-trar signed by After

The law requires that the death certificate be executed

or Attending Physicien:

within 24 hours a To the Funerel I

Division of Vital Records, P.O. Box 68760.

2. Date of Death Month Day 22, 2004 Carter, Jr December 9:15 AM 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Montgomery Holy Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

54 Yrs Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 √ M 2 □ F 54 224-72-4093 Feb 19, 1950 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 11 Yes 2 No St. Mary's Great Mills Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 45888 Chancelors Run, Apt. 1103 20634 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Crop Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rovilla Johnson Eddie Carter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 46475 Midway Drive Lexington Park, MD 20653 Eddie Carter, III 20a. Method of Disposition

Y□ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 4 ☐ Donatjon 5 ☐ Other (Specify) Bland Family Cemetery 12-29-04 Warrenton, VA 21. Signature of Funeral Service Licensee 22 Joynes Funeral Home P.O. Box 3633 Warrenton, VA 20188 inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. In rediate / ause (Final disease or ondition resulting in death) Myocardial Infarction Due to (or as a consequence of): Hypertension Sequentially list conditions, if any, leading to immediate name Enter I Industryin. Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last Chronic Pancreatitis Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy performed? 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 Ă DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of dean (Item 23a) (Type, Print) HAMPSHIRE AVE. SILVER PANG MO 12113-New

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 5 2005

32. Registrar's Signature

			For	State of Maryland					_	.
			For State Registrar		Cei	rtificate of	Death		Reg. No)	11077
	Physicia	an	1. Decedent's Name (First, Middle, Last)			0		2. Date of De Month December		ar //
	/Medic	al	Clotilde 4a. Facility Name (If not institution, give s	stroot and number		Casey	or Location of De		4c. County of C	
	Examin	er	Doctor's Community			Lanham	or cocation or De	au i	Prince (
_	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I.	ast birthday)	If Under 1 Year Months Days		Irs. 8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		124 24 3322	1м 24⊡	Yrs.	Working Days	Tiodis	Nov. 2	, 1911	Guyana
	nand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	a-fsh	tor	Maryland Prince (George's Lan	ham					1∭Yes 2□No
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show ant, the Macical Examiner must be notified a	Funeral Director	10e. Street and Number			10f. Zip Code 2070	16		10g. Citizen of Wha	t Country?
	sath w	eral	7022 Kepner Court	12. Was Decedent Ever in U.	S 12 1			(Specify Vec or No	U.S.A.	American Indian,
· ^	fter de r Item ilner	Fune	11. Marital Status 1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No				(Specify Yes or No lerto Rican, etc.)	Black, V	White, etc.
Maryland 21215-0036	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🛣 No	Specify:		Specify:	Black
2	"netu	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Deced (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b. Kind of Busin	ess/Industry
2	withir lene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		lerical	3 <i>a)</i>		New Yor	k Citv
5	e filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle	, Maiden Surname)	
/lar	Menta Menta arked	To E	Joseph A. Casey				Franc	es Hayes		
Jan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then. Insturat, or Items 23a or 28a-1 show appring or other treumatic event, the Marical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Ty)						er, City or Town, Sta. , MD 2091	
e)	1 and Health em 27		John Casey (Nephe			sition (Name of natory or other pla		Date	20c. Location - City	
JOIL	ages ent of ht: If it		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State		natory or other pla Cemeter		7/05	Bronx, N	
Baltimore,	mit. F partm portar y injui		21. Signardre of Funeral Service License					hapels, I		
<u> </u>	Depa Impo eny ii		Dennison	lmar_	5	19 Clint	on Ave.	, Brookly	n, NY 112	38
П			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death ne cause on each line.	. Do not ent	er the mode of dy	ing, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical-		Immediate Cause (Final disease or condition resulting in death)	12 esp	rate	in to	ailure			
	Examiner			Due to (or as a consequ	ience of):	Fai lux	. 11	uvem;	C.	
	P = 1	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	rance of).	, ,		VICINI	~	
	ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
760,	ires that the death certificate be executed signed by the attending physician and deedeched for use as the burial-transit	cal E	and the second s		ience or).					
687										
Box	th cert ending	an/M	23b. was decedent pregnant	3c. If yes, outcome of pregnat		Ectopic pregnanc	ev		23d. Date of	
O.	Physicien: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as it.	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)	,		Month	Day Year
<u> </u>	that the	/ Ph	Part II. Other significant conditions con	ntributing to death but not resu	ilting in the u	nderlying cause g	ven in Part I.	23e. Did t	obacco use contribut	e to the cause of death?
ds,	puires n sign		Preamon:a					10	Yes 2□No 3□	Probably 4 Munknown
CO	aw requir s been si 2 should	plete	·					24a. Was		autopsy findings available
Vital Record	ding Physicien: The tav h. After this certificate has funeral director, page 2	Completed							ormed? deat	
/ita	cien: ertific ector,	Be (25. Was case referred to medical examiner?	lospital:		0.		Death (Check only o	one)	
of	Physic this cral dire	. To	1 Yes 2 No	1 Depatient 2	ER/Outpatier 28b. Time or	IL 3 DOA		_	dence 6 Other (S	Specify)
on	Attending in death. ector: After by the funer	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?]Yes 2 ☐ No		now injury coodings	
Division of	r Atter er dea rector by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To		r Rural Route Number,
	urs aft urs aft rel Di									
	Hosp 24 hol Fune stely fi	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	n occurred at the t vestigation, in my	ime, date and pla opinion, death or	ace, and due to the ccurred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the 1	Med	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
	/ -	1	> Samuel	ASFAW,	mp	MOD	406 11	,	1/3/2	2005
	indi		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)		HAAL MI	i comit	322
	1		011110 Ch / 131/100	2 Registrar's Signal	D LUC	IL FOAL) LAW	HAM HI) 20706	0
45	Sta Registi		31. Date filed (Month, Day, Year) 200	5 Registrar's Signa	God					

			State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No. 2 () ()
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year DCember 29 2004 100 PM a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral Director	4	Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 Months Days Hours Min. 1 Jan. 2,1939 Virginia
	death with the Maryland ims 23a or 28a-f show r must be notified at	Director	10d. Inside City Limits 10d. County 10d. City, Town or Location 10d. Inside City Limits 1 □ Yes 2√2 No 10d. Street and Number 10f. Zip Code 10g. Citizen of What Country?
920	after or its	by Funeral	2529 S. Synder Avenue 21219 United States 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 252 No If Yes, Give Yes, Give Yes, Give Yes, Give Yes or Orates: 252 No In Yes 2 No Specify: 252 No Specify: White
121215-0036	2 hg	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) 12 Years Counselor 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Treatment Counselor Covernment
Maryland	should by and Menta la markad aumatic ev	To Be	18. Mother's Name (First, Middle, Maiden Sumame) David Colvin Rachel Griffin
Baltimore, I	it. Page rtment o rtant: If njury or		20b. Place of Disposition Service Corp 1/3/2005 1
			Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final
8760,	eath certificate be executed Medical Examiner and physician and for use as the burial-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
.O. Box 6	0 0	Physician/Med	FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1
ords, P	requires een sign	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown
of Vital Records,	The lavate has	Be Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Peulipi Zewia Diabetes Mellitus HTW 1 yes 2 No 25. What has a referred to medical 26. Place of Death (Check only one)
Division of \	ng Phys tter this	Certification; To	Yes 2 No Hospital: 1 Inpatient 2/5 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Cotalent of determined at least one of the control of the c
Ö	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	edical Cert	29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Med	and manner stated. 29b. Signature and title of certifier DOUTED 29c. License number Documber December 29d. Date signed (Month, Day, Year) December 29d. Date signed (Month, Day, Year)
1	12 Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) \$50.5 Hoph sing 350.0 Concile 100.0
	Registr	ar	JAN 0 5 2005 Maries 15 April

Ref# 4266549

			1 - For State Registrar	, ,,,,,	State		land / Dep <i>Ce</i>		t of H	ealth a		lental Hyg	iene	004	41879
	Physici /Medio Examir	cal	1. Decedent's Name (Mary (4a. Facility Name (If no	Catheri	ne Capoi			4b. City,	Town, or	Location o	of Death	2. Date of Deal Month December	r 30,	Year 2004 unty of Death	3. Time of Death 3:40 P
	Funeral Director		Anne Aruno 5. Social Security Num 185–18–163	nber 6	lical Cer Sex 1□M XXF		yrs. last birthday) Yrs.	Ann If Under Months	apol 1 Year Days	is If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, 8-26-19		9. Birthy Cou	del place (State or Foreign ntry) asylvania
	e Maryland Sa-f show	ctor	Usual Residence of Di 10a. State 1		rundel	10	c. City, Town or Lo		Le						10d. Inside City Limits 1 ☐ Yes 2 X No
	uth with th	al Directo	10e. Street and Numb		Drive			10f. Zip	Code	2103	35	1	0g. Citizen US	of What Coul	ntry?
315-0036	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Items 23a or 28a-f show ant, Ite Madical Examinat must be rediffed at	d by Funeral	11. Marital Status 1 □ Never Married 3 🏋 Widowed 4	Divorced	If Yes, G Year or I	orces? 2.[XX]No ve		1 ☐ Yes	2 <mark>⊠</mark> No	Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	1	Race - Americ Black, White, ecify:	
7	be filed within 72 ital Hygiene. Id other than "nat	Completed	(Specify Elementary/Second 12th 17. Father's Name (File	ary (0-12)	grade completed; College (1-4or 5+)	(Give	dent's Usua kind of woi DO NOT us omemak	rk done d se retired,	luring most)		ng	<u>H</u>	f Business/In	dustry
Maryland	m = 0 %	To Be	Peter	J. Dav	<i>r</i> in					1	Nell	(First, Middle, McDonal	đ		
, Mar	and 2 sh salth and n 27 is m		19a. Informant's Nam- Lawrence				1007	New I	Dawn	Ln.,		nton, Ma			
baltimore,	Pages 1 nent of Ho int: If iter iry or oth	-	20a. Method of Dispos 1 Burial 2 0 4 Donation 5	Cremation 3	□Removal from	Ciaio	Ob. Place of Dispo cemetery, cree Gate of H				D 1-4-(on-City or To Sprin	
Dall	permit. Pages 1 and 2 should by Department of Heatilb and Menta Important: If item 27 is marked any injury or other traumatic ex <u>once</u> .		21. Signature of Fund	Al Service Lic	ensee		22	. Name an	d Addres	s of Facility	Geo Islan	orge P. nd Rd. E	Kalas	Funer	al Home
on,	cate be executed /Medical Examiner the primal-transit	dical Examiner	23a. Part1. Enter the shock, or heart findisease or condition resulting in death) Sequentially list condition and the shock of any, leading to immediate. Enter Underly Cause (Disease or institutional indicated events resulting in death) Las	itions, ediate	a. Due to	(or as a co	1 -	ak		n, such as o	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
O. DOX 0	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent print the past 12 mc 1 Yes 2 14 9 Unknown	onths?		oirth 2 🗌 nant at time	Fetal death 3	Ectopic pre Other (spe						Date of delive	ory Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significa	ent conditions	contributing to d	eath but no	t resulting in the u	nderlying ca	luse give	n in Part I.		11	acco use co		e cause of death?
ב	The lay ate has page 2	e Completed	25. Was case referred	to medical						OS Place	of Dooth	24a. Was an autopsy perform 1 Yes 2	ed? ≅No	prior to cor death?	osy findings available inpletion of cause of 2 No
JIVISION OF VI	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Certification; To B	2 Accident	5 Pending investigat 6 Could not determine	28a. Date (Monton) be 28e. Place	of Injury th, Day Yea	At home, farm, str	28 M	Bc. Injury Work 1 Y	r: 4 🗆 Nur	sing Hom 2	ne 5 Resider 8d. Describe how 8f. Location (Str. City or Town,	once 6 00	urred	
	Hospital 24 hours Funeral etely filled	edical C	29a. Certifier (Check only one)	Certifying I	emmer: On the p	best of my asis of exa ner stated.	r knowledge, death mination and/or inv	occurred a	it the time	e, date and inion, death	place, a	nd due to the ca d at the time, da	use(s) and te and plac	manner as st	ated. the cause(s)
	vithin To th compl	Me	29b. Signature and title	e of certifier			us.		License	number C41		29	i i	ned (Month, L	
17	N		30. Name and address	s of person wh	o completed caus		(Item 23a) (Type,	Pring Mi	chal	Star	zior	18, 4.D,	401		
	Sta Registr		31. Date filed (Month,	Day, Year) 0 5 20	6	egistrar's S									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Certific	cate of	Death		Reg. No. 2	nn.	1. 1000
П	Physici	ian	1. Decedent's Name (First, Middle, La	ist)					2. Date of De		Year	3. Time of Death
	/Medi		_Dorothy Freda Dul						Dec.		004	12:30AM
	Examir	ner	4a. Facility Name (If not institution, given	e street end number	r)			4b. City, Town, or	Location of Deat	101.000	y of Death	
			Manor Care-Rossv:					Rossvi			timore	
	Funeral Director		5. Social Security Number 6. S 216160733 Usual Residence of Decedent	Sex 7. A 1 □ M 2 □ F	nge (In yrs. last b 82	Yrs.	Inder 1 Year oths Days	If Under 24 Hrs Hours Min	. (Month, Da	th ay, <i>Year)</i> 21–1922	1	lace (State or Foreign try) ryland
	yland M M		10a. State 10b. County		10c. City, To	wn or Location					1	0d. Inside City Limits
	Mar Sal	호	Maryland Baltimo	ore			Balti	imore Cou	ınty			1 ☐ Yes 2 ☑ No
	15 th	Director	10e. Street end Number			10f	f. Zip Code			10g. Citizen of	What Cour	itry?
	th wi	ai	503 St. Patrick W	3d.				21206		USA		
	eeb r	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U,S.	13. Was D	ecedent of H	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No	- 14. Ra	ce - Americ	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Evaminar must be notified at once.	Š	1 ☐ Never Married 2 ☐ Married ③☐ Widowed 4 ☐ Divorced	1 ☐ Yes X2/12 If Yes, Give Year or Dates:	KNo		es XXXNo		to Alcan, etc.)		ock, White, fy: Whit	
<u>7</u>	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16	a. Decedent's (Give kind o	Usual Occup f work done	oation during most of wo d)	rkina	16b. Kind of E	Business/Ind	dustry
12	vithin	튵	Elementary/Secondary (0-12)	College (1-4or	5+)			d)	3			
2 2	lied y lygie her t		8th grade 17. Father's Name (First, Middle, Last,	<u>N/A</u>		Homema	ker	10 Mathada Na	me (First, Middle			Own Home
a	ntall ed or	B	Ernest Haywood	70					Foster	, maiden Sumai	ne)	
₹	shoute nd Me mark matie	မ	19a. Informant's Name/Relationship (Type Print)	10	h Mailing Add	Irace /Straat	and Number or R		os Citu os Tour	Ctate 7:a	0-4-1
Š	od 2 s Ith ar 27 is			** *	-			Lck Rd. E		-		21206
ē,	f Hea		Charles R. Duley 20a. Method of Disposition	'OL' (2011)		of Disposition			Date	20c. Location		
Ê	Page ento nt: if i		XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation ▲ ☐ Other (Specif			ens of I			1-3-05	Baltimo		
Baltimore,	nit. Partmortar		21. Signalure Fureral Service Licer		1			on of English				
	Pen firming) 1	· forald	_ Hass	ale	7401	Belai	r Rd. Ba		Md. 23		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each I	d the death. Do ine.	not enter the i	mode of dyir	ng, such as cardia	c or respiratory a	rrest,	i	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final	0			Do.	0			-	Onset and Death
-	Examiner		disease or condition resulting in death)	a. 0	25626	me	bee	tme				
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	certificate be executed nding physician and use es the bunal-transit	Examiner	Sequentially list conditions	b	Due to tor as a	J CQ	olt.	, of	tation mutrito			
ð,	e exe ian al urial-t		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e.	noto -	cala	(m	mal	mutait	_		
98/80	ate b hysic the b	lica	that initiated events resulting in death) Last	C	Due to (or as a	consequence	of):		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u> </u>		
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o n	of the art			d.	1000			B - E - T	/			
j	0 0 0	Physician	Part II. Other significent conditions of	ontributing to death b	out not resulting		-	en in Part I.	23b. Did 1	tobecco use co	ntribute to	the ceuse of deeth?
ŗ.	that the ed by detach		Degenah	m Ji	ant	D140	are		10	Yes 2□ No	3 Prob	ably 4 Unknown
ecords,	requires that the neen signed by th hould be detache	d by	0						24a Wes	an autopsy	24b We	re eutopsy findings
ទូ		Completed							perfo	rmed?	ava	ilable prior to
e L	sician: The law celficate has b	鬞								/		eath?
I a	in: Ti ificate or, pe		25. Was case referred to medical			•				res 2□No	1 🗆	Yes 2□ No
>	ysician: is certifica director,	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2□ER/O	utnationt 3	DOA Oth		ath <i>(Check only o</i> Iome 5□ Resid		/2	
5	E E =		27. Manner of Death	28a. Date of Inju	ıry 28b.	Time of	28c. Injun Work	y et		now injury occur)
<u> </u>	tending leath. tor: After the funer	aţio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly 10al)	Injury M		Yes 2 □ No				
DIVISION OF	i or Attending Physician: after death. Diractor: After this certific d in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	iury - At home, f c. (Specify)	arm, street, fac	ctory, office		28f. Location (S City or Tow	Street and Numb	er or Rural	Route Number,
ב	itaio Insaft rai Di	Cer										
	e Hospital or / 124 hours after e Funeral Dira letely filled in t	edical	29a. Certifier (Check only one) The Certifying Physical Example (Check only one)	ysician: To the best liner: On the basis of and manner st	t examination at	e, death occurr nd/or investigat	red at the tim tion, in my o _l	ne, date and place pinion, death occu	, and due to the or rred at the time, o	cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
	2.520	Me	29b. Signature and title of continer	and mariner of			29c. License	e number		29d. Date signe	d (Month, D	Pay, Yeer)
	1/1	X) Jan	tal	_ M	D	D	31464		12(31		
ĺ	000	2"	30. Name and eddress of person who	completed cause of c	death (Item 23a)	(Type, Print)				•		
	U	,	Stoals A. H	13 Harr 1	821	N. G	UTAV	72 V	Smite -	308 1.	Ball	MD 2120
	Stat Registra		31. Date filed (Month, Day, Year)		ar's Signature	broste	s					

Emerson, Elizabeth Baltimore Maryland 21215-0036 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For AMEND ITEM FREGISTRA	#9,15,16a&b,1	/land / Dep L 7,18,19	Sh 20a-c	Death)	ing Me ER FH 2/02/0	111ai ⊓yg. G840 15 JH №	ene 2001	+ 41881
			1. Decedent's Name (First, Middle, L						Date of Deat	n	3. Time of Death
	Physici: /Medic		Elizabeth Emer	cson				D	Month	er 25 20	
	Examin		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, Town, o	r Location o	of Death		4c. County of De	
			The Memor	ial Hos	PITAL	EAS	TON	′		TAID	xof-
	Funeral				yrs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min	Date of Birth (Month, Day, ept 28,	Year) 9. B	Birthplace (State or Foreign Country)
	Director	ļ	222-16-2486	1□ M 2[X F	76 Yrs.		1.00.5	Se	ept 28,	1928 DEI	AWARE
	ind W		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ncation					10d. Inside City Limits
	eho	7	MD Talbo			ton					1 ☐ Yes 2X No
	he M	ect		,,,	Las						
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	Funeral Director	10e. Street and Number	_		10f. Zip Code			10	g. Citizen of What (Country?
	a 23	rai	505 Goldsborough					601		USA	
	er de item	une	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of h If Yes, specify Cub	lispanic Orig an, Mexican,	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14. Race - An Biack, Wh	nerican Indian, nite, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2🎇 No	Specify:			Specify:	white
21215-0036	hou	edit	15. Decedent's I		16a Dece	dent's Usual Occup	ation			6b. Kind of Busines	
15	in 72 "na ledic	Completed	(Specify only highest g	rade completed)	(Give	kind of work done DO NOT use retire	during most	of working	unk	Ob. Killa of Busines	unk
7	than than	E	Elementary/Secondary (0-12) unk 7th	College (1-4or 5+) unk		IRSE	,			HOSPITAL.	
D	filed Hyg other		17. Father's Name (First, Middle, Las			unk-	18. Mother	r's Name (F		laiden Sumame)	1
au	id be ental ked ic ev	To Be	CLINION JOHNS	ONT		dik	FT.T'	7 ARFT	H TURNI	rD	unk
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at one.	-	19a. latorman's Name Relationship		19b-Maili	na Arkross (Street					, Zip Code)
ž	nd 2		the Memorial Ho	ospital	2 19	S. Wash	ington	ry,ru	et Eas	82713 ^{wn, State} , ton, MD	21601
altimore,	s 1 a f Hes item othe		20a. Method of Disposition	2	Ob. Place of Dispo	osition (Name of matory or other pla	-	Date		Oc. Location - City of	
2	Page ent o nt: if ry or		1 ☐ Burial XXX Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec	Removal from State				1 /28 /	2005 C	MBRIDGE,	MD
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ũ	Degram Peng		xmulli.	yadz	tor S	tate Anat altimore,	Omy B	oard (21201	CAMDD	Baltimore	Street
		1	23a Part 1. Enter the disease, or con	mplications that caused the					spiratory arre	DGE, MD 21	Approximate
	0		hock, or heart failure. List only Immediate Cause (Final		Hicita	ealitis					Interval Between Onset and Death
	Physician /Medical	1	disease or condition resulting in death)	Clost recipy cle Due to (or as a c	n couprop of):	W W (13					
	Examiner			Small be	ruel isch	lienua					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co							
	uted ansit	盲		240 10 101 43 4 60	insequence of):						1
Ć	n an ial-tr	Examiner	cause. Enter Underlying Cause (Disease or injury	Sepsis	insequence or):						
8760,	icate be executed physician and s the burial-transit		Cause (Disease or injury that initiated events resulting in death) Last								
		ia i	that initiated events	c. Sepsis							
89	g ph as th	edicai	that initiated events	c. Sepsis					,		
99 xo	n certifica anding ph use as th	n/Medicai	that initiated events resulting in death) Last	c. Se 78 is Du to (or as a co	ensequence of):					23d. Date of di	elivery
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			1 - For State Registrar	State of M	aryland /		artment of H <i>tificate of l</i>		Mental Hy	/gien	.004	41882
	Physici /Medic		Decedent's Name (First, Middle, MARGARET GASKINS)					-	2. Date of De Month	eath ber Da	31,200	1 3. Time of Death 205 Q M
	Examir Funeral Director		218 28 9233	eneral,	HUSPIT ge (In yrs. last i 73		4b. City, Town, or Bulling If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di MAY 10	rth	N/A 9. Bit	oth thplace (State or Foreign cyntry) XYLAND
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	with the	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What C	•
	heath v	eral	1520 NORTH AVENUE	12. Was Decedent	Ever in U.S.	13. \	212 Vas Decedent of Hi		necify Yes or No	n- T	U.S. A	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 le marked other than "neturel", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Evartment be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces	?		Vas Decedent of Hi f Yes, specify Cuba I □ Yes 2∏ No	n, Mexican, Puert Specify:	o Rican, etc.)		Black, Whi	te, etc.
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Maryland	should be nd Mental marked o	10	PHILLIP HUTTON					MINNIE CI				
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Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other once.	8	20a. Method of Disposition 1 □ Burjal 2 ☑ Cremation 3	□ Bomoval from State	como	of Dispo tery, cren	sition (Name of natory or other place	»)	Date	20c. L	ocation - City or	Town, State
Ē	t. Pag rtment rtant: I		`4 □ Bonation 5 □ Other (Spec	city)		MOU	NT CREMAT	ORYJANUA	RY 5, 2	005	BALTO,	MARYLAND
Ba	Depa Impo eny ii		21. Signature of Funeral Service Lic	ensee de	weren							NERAL LOME RYLAND 21213
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause y one cause on each I	d the leath. Do	o not ente	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a brainst			provascu	lar 1	tecide	nt		Onset and Death
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	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):	1 7	2 /.				
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	quires that en signed b	by	Part II. Other significant conditions	contributing to death b	out not resulting	in the ur	derlying cause give	n in Part I.		obacco i		the cause of death?
I Records,		Completed							24a. Was autor perfo		prior to death?	itopsy findings available completion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital: , , ,				26. Place of Deat		one)		
	g Phys er this eral di	n; To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Inju	ent 2 ER/C	. Time of	28c. Injury	at	ome 5 Residente 128d. Describe 1			cify)
Sior	tending eath. or: After the funer	catlo	1 Natural 5 ☐ Pending investigati		y rear)	Injury	Work' M 1□Y	es 2 □ No				
Division of	f or Attendater death	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of In	ury - At home, c. (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tov	Street an vn, State	d Number or Ru)	ral Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	Physicien: To the best iminer: On the basis o and manner st	r examination a	ge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, nion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. License				e signed (Montl	
-	1				"BUMA	22 A	-	523		12	131/04.	
- X	21		30. Name and address of person who Maulik Bh	alani, V.	n.D. 9	(Type, F	Mary/	and C	gener	al	Hosp	ital
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5	459	ar's Signature	A					1	

DHMH 17 Rev 1/2001

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			1_ For State	State of Maryland /	Department of H	Health and Me	•	-	1. 1000
	Physici /Medi	cal	1. Decement's Name (First, Middle, Last) October 4a Facility Name (If not institution, give :	Groom	Certificate of	2	2. Date of Death Month	Day Zyear	3. Time of Death
	Examir Funeral Director	ner	5. Social Security Number 6. Sec 212 22 1425	Hospital of	DA time	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yo ULY 2,	9. Birthpl Coun	I/A lace (State or Foreign try) AROLINA
	r 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD N/i 10e. Street and Number		ORE		10g.	Citizen of What Coun	0d. Inside City Limits 1 Yes 2 No try?
036	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Mooisal Everningt must be notified at	by Funerai	1720 ASHLAND AVE. 11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes. 2 No If Yes. Give Year or Dates:	21205 13. Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:		J.S.A 14. Race - America Black, White, 6 Specify: BLA	etc.
d 21215-0036	d within 72 giene. r than "na the Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) BA 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5+)	ia. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired DUNSELOR FOR	during most of working d)	EA	STEND INC.	dustry
Maryland	nd 2 should ballth and Menta 27 Is marked r traumatic et	To Be	SILVER SHEPPARD 19a. Informant's Name/Relationship (Ty) MAGGIE GREEN (DAUGI		9b. Mailing Address (Street AKIN CIRCLE	GUSSIE and Number or Rural F	Route Number, C	ity or Town, State, Zip	Code)
Baltimore,	permit. Pages 1 ar Department of Hea Important: If itam any injury or other once.		20a. Method of Disposition 1	emoval from State GARRIS	of Disposition (Name of tery, crematory or other place SON FOREST VE	ETERANS CEM	ETERY BA	CRUGGS FUN	ARYLAND ERAL HOME
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	cations that caused the safe. Do each line.	e of the mode of dying the office of the off	+	espiratory arrest,		Approximate Interval Batween Onset and Death
68760,	cate be executed oblysician and the burial-transit	dicai Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):				
.O. Box	The law requires that the death certificat. Ite has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dear 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)	1		23d. Date of deliver Month	y Day Year
ords, P.	w requires that been signed t should be det	þ	Part II. Other conditions of	tributing to death b	the underlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
Vital Records,		Be Completed	25. Was case referred to medical			26. Place of Death (C	24a. Was an autopsy performed 1 Yes 2	? prior to com	sy findings available pletion of cause of
Division of V	문 등 별	은	27. Manner of Death Natural 5 Pending 2 Accident investigation	ospital: 1 patient 2 ER/C 28a. Date of Injury (Month, Day Year) 28b.	Time of 28c. Injury Work	er: 4 Nursing Home		6 Other (Specify)	
Divis	To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	ai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Town, St		
	To the Hospital or within 24 hours afte To the Funaral Director Completely filled in h	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifler	ner: On the basis of examination a and manner stated.	29c. License	pinion, death occurred	at the time, date	and place, and due to t	the cause(s)
7	210		30. Name and address of person who per	mpleter cause of death (Item 23a	(Type, Print)	4163	102+1	2/31/2	2004 Strond
	Sta Registr		31. Date filed (Month, Day, Year), JAN 0 5 2	32. Registrar's Signature	Aprile 11	100	es Le	ANTON .	

Lee J. Gatewood 04-8301 DOS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

,,,			1 - State Registrar	State of M	aryland / De	epartme <i>Pertifica</i>			nd Me	, ,	iene	0.1	Ē., 25
	Physici /Media		1. Decedent's Name (First, Middle, Last) Lee J. Gatewoo]	2. Date of Dea Month Decembe	r 24,	2004	1110 a M
	Examir	er	4a. Facility Name (If not institution, give s 301 McMechen Stree	et #419		В	altim					ty of Death	
	Funeral Director		5. Social Security Number 6. Sex 239-54-6535	M 2□F	ge (In yrs. last birtho	Months	er 1 Year Days	If Under 24 Hours	Min.	8. Date of Birth Month Day Dec 17,	^{Year)} 37	9. Birth Cou Nort	place (State or Foreign fry) Carolina
	Maryland a-f show	tor	10a. State 10b. County MD	-	10c. City, Town o	r Location							10d. Inside City Limits 1 X Yes 2 ☐ No
	with the	Direc	10e. Street and Number 301 McMechen Stre	et #419		10f. Z	ip Code	1217		1	0g. Citizen of	What Cou	ntry?
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show ta Madreal Evantinar must be rediffed at	by Funeral Director		12. Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates:	Ever in U.S. ? No	13. Was Dec If Yes, sp	edent of Hi ecify Cuba		n? (Spec Puerto F	cify Yes or No- lican, etc.)	14. Ra Bl	ice - Ameriack, White,	etc.
Maryland 21215-0036	d within 72 ho giene. Ir than "natur It e Medical I	Completed	15. Decedent's Educity only highest grade Elementary/Secondary (0-12) 1.2			fe. DO NOT	rork done o	luring most o)	f workin	g	16b. Kind of	Business/Ir	
yland 2	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last)					18. Mother's		(First, Middle, I	Maiden Suma		
e, Mar	s 1 and 2 should if Health and Mer Item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Ty, Donald Lee Ratlif 20a. Method of Disposition			Turne	r Str			Route Number		7360	
Baltimore,	Pages nent of nnt: If It ury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 🕅 Other (Specify)	in stat	cemetery,	crematory or	other plac						
Bal	permit. Departn Importe any inju		2 Signal of Funeral Service Bicense	Par Din	ector	State Balti			ard 1201	655 W.	Balti	nore	Street
	Pnysician /Medical Examiner	ler	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cras	ine. 128/P/86 s a consequence of)	tic (desa		//	516		Approximate Interval Between Onset and Death
8760,	ate be executed thy sician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as	s a consequence of)								
O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death	3 Ectopic 5 Other (-			I	ate of deliv	ery Day Year
Δ.	quires that n signed b uld be deta	by	Part II. Other significant conditions con	tributing to death	out not resulting in th	ne underlying	cause give	en in Part I.			pacco use cor es 2 🗆 No	atribute to t	he cause of death?
Vital Records,	The law requires that sate has been signed b page 2 should be deta	Completed						<u> </u>	_	24a. Was a autops perform	у	Were auto prior to co death? 1 \(\text{Yes}	ppsy findings available impletion of cause of
Vita	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner? 1 \(\overline{\text{V}} \) Yes 2 \(\overline{\text{No}} \) No	ospital: 1 ☐ Inpati	ent 2 ER/Outp	atient 3□ □	Othe	_		(Check only on		has (C	vat scene
ion of	ing After une	-	27. Manner of Death 1 Satural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		e of	28c. Injury Work		2	8d. Describe ho			vat scene
Division	itel or Attend rs after death ral Director; red in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, farm tc. (Specify)	, street, facto	ry, office		2	Bf. Location (St City or Town	reet and Num , State)	ber or Rura	al Route Number,
	To the Hospitel or Al within 24 hours after or To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☑ Medical Examin		of examination and/o								
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10			OCM			2	9d. Date sign Deceml		Day, Year) 4, 2004
			30. Name and address of person who co	-C. /IVI	/	rpe, Print) 111]	Penn	Street	, Ba	altimore	e, MD 2	21201	
	Sta		31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	ande!							

State

Registra

31. Date filed (Month, Pan Year)

5 2005

Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician Year O4 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NIA Roland Park Place Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 25,1926 Balt. MD **Funeral** Birthplace (State or Foreign Country) Days Months Hours 1□M 2**X**F 217-20-5196 78 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f should Medical Examiner must be notified at TX Harris San Jacinta Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10717 Norvic 77029 USA Funerai permit. Pages 1 and 2 should be filed within 72 hours effer dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or Hamphiny or other traumatic events. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Kessler Goldie Alice Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olyn Hill / Husband 0717 NOrVIC San Dacinta 77029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗷 Removal from State 113105 Wood laws 4 Donation 5 Dother (Specify) Cem. Houston 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave. Baltimore Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) pertension Examiner Due to (or as a consequence of) Examiner The law requires that the death certificete be executed ettending physician and for use as the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No þ page 2 should be Completed 24b. Were autopsy findings availeble prior to completion of cause of death? 24a. Was an autopsy performed? has anemyl this certificate 1 Tyes 2 Devio 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours efter death."

To the Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: P 1 Yes 2 No Other: 4☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number-City or Town, State) in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of sectifier 29c. License number 29d. Date signed (Month, Day, Year) D35102 James (

Baltimore

MANILAND

FUAD

State Registrar 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Don

31. Date filed (Month, Day, Year)

164

32. Registrar's Signature

Tunbri dge

04-08458 Bernice Holmes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State Of Ivid	Ce.	rtificate of L			2004	41887
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	/Medic		BERNICE M. HO						30, 2004	17:35 M
	Examir	ner	4a. Facility Name (If not institution, give s 3500 Fairview Aven			4b. City, Town, or Baltin			4c. County of Deal	th
-	Funeval		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	N/A	hnlace (State or Foreign
L	Funeral Director			M 20XF	67 Yrs.	Months Days	Hours Min.	(Month, Day, Y MAY 13 1	(ear) Co	hplace (State or Foreign ountry) ARYLAND
	yland now		10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
	B Mar	ctor	MARYLAND N/A		BAI	TIMORE				1XXYes 2 □ No
	ith th	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
	s 23e	ra	3500 FAIRVIEW AV			2121			U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examinat must be troubled at ance.	by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	 Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates: 	lo	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2☑ No		pecify Yes or No- Pican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	2 hou	Completed by	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	tion	16	Bb. Kind of Business/	
215	thin 7 e. an "n Wed	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Give	kind of work done d DO NOT use retired)	uring most of worl	king		•
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Maryland	d 2 should be filed within in and Mental Hygiene. 7 Is marked other than "I treumatic event, the Mea	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma	iden Sumame)	
Ž	hould d Mer marke matic	2	unknown 19a. Informant's Name/Relationship (Typ	e Print)	10h Maili	on Address (Street a	MARY M		City or Town, State, 2	T- 0- 4-)
S	od 2 s lth an 27 ls		Jack B. Wicker/Bro						Maryland 2	,
ē,	s 1 ar f Hea item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			c. Location - City or	
Ë	Pages nent of I int: If it		1 TABurial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify)	moval from State	-	natory or other place IORIAL PAR	1	8-05 E	BALTIMORE,	MARYLAND
Baltimore,	permit. Departm Importa any inju		21. Sign wire of Fune Service License	/	22 V	. Name and Addres	s of Facility BROWN CC	MMUNITY F	FUNERAL HO	
			23a. Part1. Enter the disease, or complice	ations that caused	the death. Do not ent	.206 W NOF er the mode of dying			t,	Approximate
	Physician		shock, or heart failure. List only on		elerotic Ca	rdi orraco	Jon Dice			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a consequence of):	itutovasci	ITAL DISE	ase		
	Examiner		Sequentially list conditions, b.							
	Sit 9d	iner	ri any, leading to immediate	Due to (or as	consequence of):					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):					
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68760,	tificate ig phys as the	fedical	d.							
P.O. Box	ne death cer the attendir hed for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	that the		Part II. Other significant conditions cont	ributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ords,	w requires t been signe should be	ted by						1 ☐ Yes	2□No 3□Pro	obably 4 Unknown
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Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				h Check on one		
of	Phys ir this oral dir	To :	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 - Inpatie		t 3 DOA		me 5 Residence 28d. Describe how		ify) SCENE
Division	Attending Phier death.	tlor	1 X Natural 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	Year) Injury	Work	es 2 □ No	200. 2000.20 11011	injury occurred	
Visi	after death. Director: A in by the fo	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm, str	eet, factory, office			et and Number or Ru	ral Route Number,
Ö	tel or A	Certification;	4 _ nonneide	building, etc	. (Эрвспу)			City or Town, S	otate)	
	To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1. Certifying Physical Examination (Check only one) 2. Medical Examination (Check only one)	cian: To the best of er: On the basis of and manner sta	f my knowledge, death examination and/or in- ted.	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	. 0	20	29c. License		29d.	. Date signed (Month	, Day, Year)
		2	Walle	ne Kal	Oel us	0.C.	M.E.	Dec	ember 31,	2004
0	16		30. Plane and address of person who con	npleted cause of de	ath (Item 23a) (Type	enn Stree	t, Balti	more, Mar	yland 212	01
ľ	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5	32. Registra 2005	r's Signature	book				

			For State Registrar	State	of Maryla		artment of H rtificate of		d Mental Hy	giene Reg. No. 0 () [-	41888
	Physic	ian	Decedent's Name (First, Middle NATTON)		10		-		2. Date of Do Month		Year	3. Time of Death
	/Medi Exami		MAUDE ALI 4a. Facility Name (If not institutio				4b. City, Town, o	or Location of De	DECEMB eath		2004 by of Death	9:00 P.M
				ROAD			BEL A				FORD	
	Funeral Director		5. Social Security Number 237–48–4042	6. Sex 1 □ M 2 □ F	7. Age (In yrs	s. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		1909	9. Birthp Cour NOR'	place (State or Foreign oftry) TH CAROLINA
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	ocation				1	10d. Inside City Limits
	8e-f st	Director	MARYLAND HARFO)RD]	BEL AIR						1 □ Yes 2√No
	with the or 2		10e. Street and Number 500 PLUMTREE F	מגס			10f. Zip Code 21015			10g. Citizen of UNITED		-
	death ms 23	Funeral	11. Marital Status	12. Was De	cedent Ever in		Was Decedent of H	lispanic Origin?	(Specify Yes or No		ce - Americ	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other treumatic svent, if a Medical Evarthing must be notified at once.		1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes G	2X No Bive		If Yes, specify Cuba 1 ☐ Yes 次 ☐ No	an, Mexican, Pui Specify:	erto Rican, etc.)		ack, White, fy: WHT:	
21215-0036	72 ho	Completed by	15. Deceder (Specify only highe	nt's Education st grade completed	d)	(Give	dent's Usual Occup	durina most of w	rorking	16b. Kind of B	łusiness/In	dustry
7	within ene. than	ldmc	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retire: SSEMBLY I	d) -		TOOT.	MANT	FACTURING
b L	e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle,	Last)		, A			ame (First, Middle			ACTURING
ylar	Menta Menta arked atic s	To	WILLIAM ALPHUS					DANA	MAE WOOD	Υ		
Maryland	d 2 sh th and th and 7 is m treum		19a. Informant's Name/Relations						Rural Route Numb		, State, Zip	Code)
ē,	s 1 an f Heal item 2 other		DELORIS WAGNER 20a. Method of Disposition		20b.	Place of Dispo	LUMTREE F sition (Name of	-	AIR, MD /2005	21015 20c. Location	- City or To	own, State
<u>m</u>	Page nent o ent: If ury or		XXBurial 2 Cremation 4 Donation 5 Other (S		n State MAI	NCHESTE	natory or other plac R BAPTIST	CHURCH	/ ZUUS CEMETER	MANCHE	ESTER	, MARYLAND
Baltimore,	ermit. Separtr mport ny inji		21. Signature of Funeral Service	Licensee		22	. Name and Addre	ss of Facility	ERAL HOM			
	GU 3 8 0		23a. Part . Enter the disease, or	complications that	caused the dea	9	1 WILLIS	CUDEFUL	WESTMIT	ARTIPIA	4D 21	1157 Approximate
	Physician		Immediate Cause (Final	only one cause on	each line.		MSION		ac or respiratory a	11631,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to	o (or as a conse		79.01	J				
ŀ	Examiner	ē	Sequentially list conditions,	b. — Due to	5.	TROK	8					
	t t insit	mine	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a coole	TM E	AITL					
oʻ	icate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conse							
8760,	cate be	dical		d		OPI	J					
9		O t	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregr	nancy				224 De		
Box	The law requires that the death certifi tle has been signed by the attending I age 2 should be detached for use as	Physician/M	in the past 12 months?	1□Live 4□Preg	birth 2 Fet nant at time of	al death 3	Ectopic pregnancy Other (specify)				ite of delive onth	Day Year
<u>М</u>	that the de ed by the detached	Phys	9 🗆 Unknown	9□ Unki								
ds,	signed d be de	by	Part II. Other significant condition	ons contributing to	death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to			e cause of death?
Records,	w requir s been si should!	lete			-				24a. Was			osy findings available
	The lay	Completed							autop	rmed?	prior to con death? 1 Yes	npletion of cause of
Vital	ector, pag	Be C	25. Was case referred to medica examiner?					26. Place of De	eath Check onl o		1 1 105	2 NO
	Phyei this c ral dira	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 = 28a. Date		ER/Outpatien	t 3 DOA Other	4 🗀 Nursing	Home 5 Hesid)
on	nding I ath. r: After e funer	ation	1_Statural 5 Pendin 2 Accident investi	ig (Moi	nth, Day Year)	Injury	Worl	rat (? Yes 2 □ No	28d. Describe i	now injuty occurr	·ea	
Division of	I or Attendated after death Director:	Certification;	3 Suicide 6 Could determined	ined 286. Plac	e of Injury - At h	nome, farm, stre	eet, factory, office		28f. Location (5 City or Tox	Street and Numb	er or Rural	Route Number,
	pitel o		200 Continu							,		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 12 Certifyin 2 Medical	i g Physician: To th Examiner: On the i and mai	le best of my kn basis of examina nner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place, a	inner as sta and due to	ited. the cause(s)
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	N N	29b. Signature and title At certifie				29c. License	1 - 1		29d. Date signed		
رب	10		NS WY.K	& m	()		03	6841	6	InNus	W Y	03,2005
1)	1		30. Name and address of person.	RAVITZ	ise of death (Ite	m 23a) (Type, I	Loud RA	VEN BI	UD Cuin	JUE-A	SALTIN	03,2005 NOF MD 21239
	Sta	te	31. Date filed (Month, Day, Year)	32.1	Registrar's Sign				54116	,,,-0 /1 /		21239
	Registr	ar	JAN	0 5 2005	Flera	10	A CONTRACTOR OF THE PARTY OF TH					

ORIGINAL

			1 - For State of Maryland / Depart Certification State of Maryland / Depart Certification Certificatio	tment of Health and Ment	tal Hygiene Reg. No. 2004 4 889
	Physici /Medi		Hernerr Lag Hall	M	ate of Death Anoth Day Year Cember 25, 2004 330 A M
	Examir		4a. Facility Name (If not institution, give street and number)	b. City, Town, or Location of Death	4c. County of Death
			329 Winston Avenue	Baltimore	N/A
	Funeral Director			Months Days Hours Min. (N	ate of Birth Worth, Day, Year) In. 1, 1938 9. Birthplace (State or Foreign Country) Massachuesett
	/land		10a. State 10b. County 10c. City, Town or Local	tion	10d. Inside City Limits
	Man a-f sh	tor	MD N/A	Baltimroe	∭ Yes 2 No
	th the	irec	10e, Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a	ral	2427 Washington Blvd.	21230	United States
36	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "netural", or itams 23a or 28a-1 show event, the Medical Exerting Evaluation at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Noivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	s Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, Yes 2 No Specify:	Yes or No- h, etc.) 14. Race - Americen Indian, Black, White, etc. Specify: White
21215-0036	72 hou	Completed	15. Decedent's Education 16a. Deceden (Specify only highest grade completed) (Give kin	nt's Usual Occupation	16b. Kind of Business/Industry
21	ithin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of working NOT use retired)	
121	tygier tygier her th			Carpenter	Self Employed
Maryland	12 should be filed within n and Mental Hygiene. 7 is marked other than "raumatic event, I'le Mus	Be			it, Middle, Maiden Surname)
Ž	thould Me mark	ဥ		Ruby W. We	esson te Number, City or Town, State, Zip Code)
<u>S</u>	5 = 2 T			aywood Place, Sykesy	
Baltimore,			20a. Method of Disposition 20b. Place of Disposition		20c. Location - City or Town, State
E	Pages nent of I ant: If it		I Burial 20 Cremation 3 Removal from State		2004 Baltimore, MD
alt	permit, Page Department of Important: If any injury or once.		21. Sign ture in Funeral Service Licensee 22. N	lame and Address of FacilityAmbrose	e Funeral Home, Inc.
-	207 29				., lansdowne, MD 21227
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	the mode of dying, such as cardiac or resp	Interval Between
8760,	be executed siclan and burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
P.O. Box 687	the death certificate by the attending phys ached for use as the	Physician/Medical	·	etopic pregnancy ther (specify)	23d. Date of delivery Month Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the under	orlying cause given in Part I. 2:	3e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
of Vital Records,		e Completed		10	4a. Was an autopsy findings available prior to completion of cause of death? ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
Division of Vit	if or Attending Physician: after death, Director: After this certific in by the funeral director,	Certification; To Be	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Work? M 1 ☐ Yes 2 ☐ No factory, office 28f. Lo	
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death or control on the basis of examination and/or investigant manner stated.	ccurred at the time, date and place, and du tigation, in my opinion, death occurred at the	ie to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
)	To the I within 2: To the I complet	×	29b. Signature charlitle of certifier (Secure MD)	29c. License number D 16354	29d. Date signed (Month, Day, Year) 12/27/2004
7	211		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin E-W-COLE 5T AGNES 900 CF	ATON AVE BALTI	MORE MD 21229
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 0 5 2005	U	

	Physici /Medic		1. Decedent's Name (First, Middle, L	uphill				2. Date of De.	/ Day	Year 2004	3. Time of Death //35 PM
	Examin			cours t	bspital	4b. City, Town, o	ore	eath	4c. County		· · · · · · · · · · · · · · · · · · ·
	Funeral Director		5. Social Security Number 2/7 -22-052/ Usual Residence of Decedent	Sex 1 M 2 F	ge (In yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Irs. 8. Date of Birt (Month, Da Nov ±5	, 1913	Country	ce (State or Foreign) Carolina
Maryland	e-f show	ctor	10a. State 10b. County MD		10c. City, Town or L Baltim					10d.	. Inside City Limits 1√ Yes 2 □ No
h with the	3a or 28 st be no	al Director	10e. Street and Number 1217 W. Fayette	Street		10f. Zip Code	21223		10g. Citizen of	What Country USA	7
72 hours after death with the Maryland	"naturel", or items 23a or 28e-f show	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	,	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Rac Blac Specifi	e - American ck, White, etc	
within	than "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) unk	Education	(Give 5+)	dent's Usual Occup e kind of work done DO NOT use retired	during most of w	vorking	16b. Kind of B	usiness/Indus	,
should be filed	d o	To Be C	17. Father's Name (First, Middle, Last Burrell Abell					lame <i>(First, Middl</i> e,			.011
and 2 sho	9 e		19a. Informant's Name/Relationship Patricia Poag/ni				and Number or	Rural Route Numbe			
t. Pages 1	nent o ant: If ary or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 ☑ Other (Spec	in state		matory`or other plac		Date	20c. Location -	City or Town	, State
Dermit.	Depa Impo any ir 2000		2 Part Lenter the disease, or co	10/11/10	stor S B	altimore,	omy Boa MD 21	rd 655 W. 201			
1	iysician Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	Sepsi		ac or respiratory at	631,	Int	oproximate terval Between nset and Death
cate be executed	physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Tieses of Tieses) that initiated events resulting in death) Last	C	a consequence of):						
certificate	attending physifor use as the	/Medicai	IF FEMALE:	d. 23c. If yes, outcome	of pregnancy				224 5-4		
the death certifi	y the	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 ☐ Fetal death 3[□Ectopic pregnancy □ Other (specify)			Mo	e of delivery nth Da	y Year
requires that	signed d be de	by	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause give	en in Part I.		bacco use conti es 2000	_	eause of death?
The law	ate has b page 2 sl	Completed					_	24a. Was a autop perfor	sy p med? c	Were autopsy prior to complete th?	findings available etion of cause of
Physician:	this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie	ent 2 ☐ ER/Outpatie	nt 3□ DOA Oth	ar	eath (Check only or Home 5 - Resid		er (Specify)	
Attending P	h. After funei	ertification:	27. Manner of Death 1			Worl	/ at ⟨? Yes 2 □ No	28d. Describe h	ow inj <i>ur</i> y occurr	ed	
lospital or Ati	in Direction	O	4 Homicide determine	d 286. Place of Inj building, et		•		28f. Location (S City or Tow	n, State)		
	within 24 hours a To the Funerel I completely filled	Medical	one) 2 Medical Exe	thysician: To the best miner: On the basis of and manner st	f examination and/or in	vestigation, in my or	oinion, death oc	curred at the time, d	ate and place, a	and due to the	cause(s)
To	To	_	29b. Signature and title of conflict.	let Shi	A, MI	> 29c. License	0529	>	enber		
1	1-1			0				1			

DHMH 17 Rev 1/2001

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Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MICHAEL HUMPHREYS December 28 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10901 Notchcliff Road Glen Arm
If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours X⊠M 2□ F Yrs. Director 35 215-84-9974 May 26,1969 Marvland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28e-f show froumatic event, the Medical Exercities must be notified at Director Dundalk 1 ☐ Yes 2 ☑ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 21222 3301 Dundalk Avenue Funeral United States 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 22 Married Baltimore, Maryland 21215-0036 þ Specify: 3 Widowed 4 Divorced White naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) United States Military 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) National Guard Special Forces 12 Years 17. Father's Name (First, Middle, Last) Be Unkn. 18. Mother's Name (First, Middle, Maiden Sumame) Mary Rita Humphreys 2 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Stephanie L. Humphreys item 27 3301 Dundalk Ave. Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1/1/2005 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician GUNSHOT HEAD Wound TO disease or condition resulting in death) 10 Minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760. Hospitel or Attending Physician: The law requires that the death certificate be Physician/Medical the IF FEMALE 156 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 No Division of Vital 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1XYes 2⊟No 27. Minner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 12-78-2004 1 ☐ Yes 2 No after death 2 Accident investigation 955 AM self inflicted gunshot 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
National Grand Aemory 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 10 901 Noteholiff Rd, Balt CTY 2105 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W HILLE 01866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hill CT. Luthowille, MD 21093 MDLe irimble ello 31. Date filed (Month, Day, Year) ₽egistrar's Signature State JAN 0 5 2005 Registrar

			1 - For State Registrer 1. Decedent's Name (First, Middle, Lasi	State of Mar	ryland				ealth a Death	and M	lental Hy	Reg. No	200	3. Time of Death	
	Physici /Medio Examir	al	RUDOLPH 4a. Facility Name (If not institution, give						Location o		DECEMBE	ER Da	19 2004	2:45 P M	
	Funeral Director		#EARTLAND HEALTH 5. Social Security Number 213-16-2040 Usual Residence of Decedent		(In yrs. last	t birthday)_ Yrs.	If Under Months	LPHI 1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da Januar	rth av. Year	RINCE GI 9. Bir 1916 Vi	thplace (State or Foreign	
336	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-f show has Madical Examiner must be redified at	Director	10a. State 10b. County MD Prince G 10e. Street and Number 3914 Wallace Road	eorge's	10c. City, T No	own or Loc rth B	rent		2				itizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If item 27 is marked other than "neturel; or items 23e or 28a-1 show mortent: If item 27 is marked other than "neturel; or items 23e or 28a-1 show eny injury or other treumatic event, the Medical Examination and the routilised at Once.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ⊠Yes 2* No If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - Ame Black, Whit	e, etc.		
Baltimore, Maryland 21215-0036	iled within 72 ho tygiene. ther than "netur nt, the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12))	6a. Decede (Give k life. D Legal	cind of wo OO NDT us	rk done d se retired)	uring most			Go	vernment		
aryland	2 should be fi and Mental H is marked of sumatic ever	To Be	Isaac Carter Jones Magdeline Hodge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number,							ge er, City	or Town, State, 2	Zip Code)			
more, M	Pages 1 and 2 ent of Health nt: If item 27 in ry or other tre		Edna Jones/Wife 20a. Method of Disposition 1 DBurial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20b. Place ceme	e of Dispos etery, crem	ition (Nan atory or o	ne of ther place	9)	D	ate	20c. L	ocation - City or	Town, State	
Baltii	permit. F Departme Importer eny injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785									1 Home			
	Physician /Medical Examiner	al resulting in death) a. Due to (or as a consequence of):											Approximate Interval Between Onset and Death		
8760,		dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (uisease or injury that initiated events resulting in death) Last	Due to (or as a of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or as of Due to (or a) Due											
P.O. Box 6	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐ Fetal dea	ath 3□E	Ectopic pro Other (sp			23				3d. Date of delivery Month Day Year	
	w requires that been signed by should be deta											the cause of death?			
Vital Records,		e Completed	25. Was case referred to medical						OG Diago	of Dooth	1 ☐ Yes	osy med? 21 No	prior to death?	topsy findings available completion of cause of 2 № No	
ot	ding Phys	ation: To B	examiner?	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y				sing Hom	ne 5 🗆 Resid	idence 6 Other (Specify) how injury occurred					
Divis	Hospitel or Attend 44 hours after death Funerel Director: tely filled in by the	Certification:	4 Homicide building, etc. (Specify) City or Town,								vn, State	·			
	To the Hospitel or A within 24 hours after To the Funerel Dire. completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)									to the cause(s)			
2	+3+8		30. Name and address if p on who completed cause of death (Item 23a) (Type,					D0054566					1-3-05		
16	Sta Registr		Sunitha Bhogavil 31. Date filed (Month, Day, Year) JAN 0 5 2	11 M.D. 12	20A E	. Jop	pa R		Cowson	n, M	aryland	i 2	1286		

			1 - For State of Registrar		artment of Health and Mortificate of Death	ental Hygier	4000	41893	
	Physici /Medi			N50N		2. Date of Death Month 2	Day Zeas	3. Time of Death	
	Examir	ner	4a. Facility Name (If not institution, give street and number Heartland Health Can 5. Social Security Number 6. Sex 7	e Center	4b. City, Town, or Location of Death Hyattsville If Under 1 Year If Under 24 Hrs.		4c. County of Death Prince Geo		
	Funeral Director		5. Social Security Number 6. Sex 7 7 - 24 - 4539 10 M 2 F 7	. Age (In yrs. last birthday) 81 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 100 11, 197	23 9. Birthpl Count Mar	ace (State or Foreign try) Yland	
	Maryland a-f show	ctor	10a. State 10b. County MD Prince George		10d. Inside City 1 ☐ Yes 2				
	th with the 23a or 28 und be no	ai Dire	10e. Street and Number 6500 Riggs Road		10f. Zip Code 20783	10g. (Citizen of What Count	ry?	
36	72 hours after death with the Marylan natural', or items 23a or 28a-f show after Executer must be rutified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deced Amed Force 1 1 8 9s 2 1 1 9s Give	es?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☑ No Specify:	ity Yes or No- ican, etc.)	14. Race - America Black, White, e	etc.	
21215-0036	in 72 ho	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	16b.	Kind of Business/Ind			
and 21	be filed stal Hygi ed other event, I	Be	unk unk 17. Father's Name (First, Middle, Last) Walter Johnson	· ·	iter 18. Mother's Name		estaurants en Sumame)	unk	
Maryland	and 2 should be ealth and Mental n 27 Is marked o	J.	19a. Informant's Name/Relationship (Type, Print) Regina Williams/daughter		ng Address (Street and Number or Rural Box 7690 Baltimon			Code)	
d'			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from St. 4 □ Donation 5 🖾 Other (Specify) in State	20b. Place of Dispo cemetery, crer	1 22 22 22 22 22 22 22 22 22 22 22 22 22	-	Location - City or Tow	n, State	
Balti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Sarvice Licensee Ronald S. Wade	reetar Si	Name and Address of Face Board altimore, MD 21201	655 W. Ba	altimore S	treet	
	Physician /Medical		23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	n line.	er the mode of dying, such as cardiac or			Approximate Interval Between Onset and Death	
	Examiner	ner	Sequentially list conditions	as a consequence of):					
58760,	cate be executed physician and the burial-transit	Ĭ.	al Examin	Cause (Disease or injury that initiated events c c Due to (or	as a consequence of):				
687		edical	d						
P.O. Box	that the death certificated by the attending for the detached for use as	5	by		h 2 ☐ Fetal death 3 ☐ it at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month D	y Day Year
	w requires that the been signed by th should be detache			þ	Part II. Other significant conditions contributing to deat	th but not resulting in the ur	• •	23e. Did tobacco	use contribute to the
al Reco	The law ate has b page 2 s	Completed				24a. Was an autopsy performed?	death?	sy findings available pletion of cause of	
of Vita	ding Physician: Th th. After this certificate funeral director, pag	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inp 27. Manner of Death 28a. Date of Medical	njury 28b. Time of	28c. Injury at 28		6 ☐Other (Specify) ury occurred		
	r Atten ter deat irector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of building.	Day Year) Injury Injury - At home, farm, streetc. (Specify)	Work? M 1 □ Yes 2 □ No eet, factory, office 28	f. Location (Street a City or Town, Stat	nd Number or Rural F te)	Route Number,	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Ce	s) and manner as stat id place, and due to the	ed. ne cause(s)					
	To the within To the comp	M	29b. Signature and title of certifier Caully Complete Co	drew	estigation, in my opinion, death occurred 29c. License number 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number 2 20c. License number	29d. Da	ate signed (Month, Da	1y, Year)	
			30 Name and address of person who completed cause of A. DEVORE M	of death (Item 23a) (Type, I	eenshung Rol H	yathi	ue mo	20781	
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 0 5 2005	istrar's Signature	W				
DH	MH 17 Rev 1/20	01	47	-					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U U 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Mary Konopka 31 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner \mathcal{B} Alice ristield lawes If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 383310 1 □ M 200 F Yrs Director New Jersev Usual Residence of Deceden Peges 1 end 2 should be filed within 72 hours effer deeth with the Marylend nent of Health end Mental Hygiene. Int: If Itam 27 ie marked other than "naturel", or items 23e or 28e-f ehow 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 le marked other than "naturel", or items 23e or 28e-f eho treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 💢 No **Funeral Director** Crisfield Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21817 3231 Sackertown Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖾 No Specify: White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joesph Sakowski Catherine Habiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Witt (Daughter) 3231 Sackertown Road - Crisfield, Maryland 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery | 1/4/05 | Sayreville, New Jersey 22. Name and Address of Facility 21. Signature of Funeral Ser Bradshaw & Sons Funeral Home hykotk Klodyuk ry Beth Bradshaw-Prui 306 W. Main Street - Crisfield, Maryland 21817 Mary Beth Bradshaw-Pruift 300 W. Main Street - Crising 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CUMONVO Examiner Physician/Medical Examiner ettending physicien end for use es the buriel-trensit Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate hes been signed by pege 2 should be detect 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 10 1 ☐ Yes 2 ☐ No efter death.

Director: After this certification by the funerel director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 | Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō To the Hospital of within 24 hours of To the Funeral D 12 Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JAN 05

2005

32. Registrar's Signature

		Amend Item 21 per		and / Departme 705/2005dhb Certifica	ent of He	ealth and l Death	Re	g. No. 🚄	004	4189	
Physic				Kelle		2. Date of Deat Month	Day	Day Year			
/Med Exam		4a. Facility Name (If not institution, give		Kerre		. City, Town, or I	December Location of Death		JO4 ty of Death	12:40a.	
		Long View Nurs	sing Home		M	anchest	er		rrol1		
Funera, Director		5. Social Security Number 6. Sec. 212–16–5058 Usual Residence of Decedent	7. Age (In)	yrs. last birthday) If Unc Yrs. Month		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 21,		9. Birthp Court Mary	place (State or Foreign htry) 7 1and	
iryland show		10a. State 10b. County	10c.	City, Town or Location					1	0d. Inside City Limits	
with the Maryland e or 28e-f ehow	ecto	Maryland Calvert		Huntingtown	n					1 ☐ Yes XX No	
death with the Maryland ms 23e or 28e-f ehow Ervust be notified at	Funeral Director	10e. Street and Number 2440 Kimberly La	Zip Code 206 3	9	10	g. Citizen of USA	What Coun	try?			
_ je 42 €	þ	11. Marital Status 1 □ Never Married ② Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	becity Cuban,	panic Origin? (Sp Mexican, Puerto Specity:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White 6b. Kind of Business/Industry			
vithin 72 ne. hen "net	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	vork done dui	on ring most of work	king 1	6b. Kind of E	Business/Inc	lustry	
d 2 filed v Hygie other t		06 17. Father's Name (First, Middle, Last)	N/A	Master	r Plum		e (First, Middle, M.	Plum!			
aryland 2 should be filed v and Mental Hygie marked other t umatic event, the	To Be	Harry H. Kelle	er		"	Ethe1		Garri:	_		
Maryland d 2 should be file th and Mental Hy 7 Is marked othe traumatic event		19a. Informant's Name/Relationship (T)		19b. Mailing Addres	ss (Street and	d Number or Rui				Code)	
'e, N 1 and Health 9m 27 wther tr		Todd Keller/ S		2440 Kimb	berly]	Lane, H					
Baltimore, Ma permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny Injury or other tra once.		1 ☐ Burial 2 M Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crematory or t. Confort (other place)	000	Date 20 L2/28/04	Oc. Location	•		
Balti permit. I Departm Importar eny Injura		21. Signature of Funeral Service License			and Address	of English				Virginia	
0 8258	100	Bryan W. Clary per DVR Valley Inc., 10W. Padonia Rd., Timonium, MD21093									
fficate be executed Examine the burial-transit as the burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consequence of)):	کردرس	•		7	Onset and Death	
		C d									
P.O.	/ Physician/N	Part II. Other significant conditions conf	ributing to death but not re	esulting in the underlying	cause given i	n Part I.		cco use cor		he cause of death?	
	Completed by						24a. Was an a performe	utopsy 1?	avail	autopsy findings able prior to pletion of cause ath?	
of Vital Rec hysicien: The law his certificate has t							1 ☐ Yes	2 No	_	res Z□ No	
OT VITAL Physicien: T this certificat ral director, pa	<u> </u>	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	ospital:		Other		(Check only one)				
O = = 0	ation: To	27. Manner of Death 1. ■ Natural 5 □ Pending 2 □ Accident investigation	1 ☐ Inpatient 2 [28a. Date of Injury (Month, Day Year)	BER/Outpatient 3 D0 28b. Time of Injury	28c. Injury at Work?			5 ☐ Residence 6 ☐ Other (Specify) d. Describe how injury occurred			
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, street, factory	Bf. Location (Street and Number or Rural Route Number, City or Town, State)						
he Hospit in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one)	cian: To the best of my kn or: On the basis of examin and manner stated.	owledge, death occurred ation and/or investigation,	at the time, d , in my opinio	ate and place, a n, death occurre	nd due to the caused at the time, date	e(s) and mar and place, a	nner as state nd due to th	ed. e cause(s)	
To the solution of the solutio		29b. Signature and title of certifie		290	. License nur	mber		Date signed	(Month, Da	y, Year)	
		Po Name and a district			25	2162		12/29	8 (0)	1	
		30. Name and address of person who com	pleted cause of death (Ite	m 33a) (Type, Print)	he of	-taite	bu Si	. 21	574		
Stat Registra	·	31. Date filed (Month, Day, Year) JAN 0 5 2005	32. Registrar's Sign	atu (1	1 1					

				State of Ma						•		_		
			For State Registrar			Ce	rtificate o	f Deati	h		Reg. No.	2001	s 4 1	896
	Physici	an	1. Decedent's Name (First, Middle, Last	1 2 4						2. Date of De Month	Day		7.7	of Death
	/Medic	al	4a. Facility Name (If not institution, give	street and number)			4b. City, Town	or Location	n of Death	12	21	2004 County of De		,5 A.M
	Examin	er	Hebrew Itome of	areater	- lale	discil.	A. C. C. C.	CXX	1:110		40.		gomes	iΛ
	Funeral		5. Social Security Number 6. \$6	x / 7. Age	(In yrs. la	ast birthday)	If Under 1 Year Months Day		er 24 Hrs.	8. Date of Bir (Month, Da	th V Year	9. B	inhplace (Stat	te or Foreign
	Director		064-07-5805	M 200 F	87	Yrs.	I WOTHING Day	3 110013		01/08	1917	Ví	rginia	
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside	City Limits
	Mary a-f sh	tor	VA		Fal	lls Ch	urch						1 [XY	es 2 □ No
	ith the	Olrec	10e. Street and Number				10f. Zip Code				-	zen of What (Country?	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show yth, the Maxical Examinat must be notified at	Completed by Funeral Director	113 Gresham Place				2204					SA		
	items items	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 Tyes 277		5. 13.	Was Decedent of If Yes, specify Cu	f Hispanic C Jban, Mexic	origin? (Spe an, Puerto	ecity Yes or No Rican, etc.))-	14. Race - An Black, Wh	nerican Indian, iite, etc.	1
936	urs af	by F	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☐ XN	lo Specif	y:			Specify:	White	
2 0	72 ho	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)		16a. Dece (Give	dent's Usual Occ kind of work don DO NOT use reti	upation ne during me	ost of worki	ing	16b. Kir	nd of Busines	s/Industry	
12	within ne. han	пр	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.		red)					-	
0 0	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)				Sales	18. Mot	her's Name	(First, Middle		tail S Sumame)	ales	
an	should be and Mental s marked o	To Be	Robert Galumbeck		Dora Wer									
ary	2 shou and N is mai		19a. Informant's Name/Relationship (7	ype, Print)			_				Number, City or Town, State, Zip Code)			
S o`	and sealth m 27		Steven A. Rogers	(Son)	20h BI	Jan	Gresham of Osition (Name of	Plac		ls Chur				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinal must be notified at ORG.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		_ ce	emetery, cre	matory or other p	lace)	2-23-			folk,	or Town, State	
	artme ortani injury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License 		0.0		2. Name and Add	iress of Fac		03	11011	LOIR,	V 21	
ã	Depa Depa Impo any ii		H.D. Oliver Funeral Apartments 1501 Colonial Ave. Norfolk, VA											
			2 a. P.u.1. Inter the disease, or comp	lications that caused one cause on each lin	the death								Approxim Interval	Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	a. Coron	pro	athe	roscle	10513	S				Onset an	eacs
			resulting in death)	Due to (or as	a con e u			A						
	I he	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
760,	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as	Due to (or as a consequence of):									
6876	cate b physic the b	dical		d										
Box 6	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							2	3d. Date of d	eliverv	
ă	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Medl	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at			⊒Ectopic pregnar ⊒ Other <i>(specify)</i>					Month	Day	Year
P.O.	at the I by Ih etache	Phys	9 Unknown	9□ Unknown										
Ś	ires th signed	by	1	ation							d tobacco use contribute to the cause of death? ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
Ö	v requ	etec	Dog 00 200	a tioy	<u>-</u>					24a. Was				
Vital Record	e la has je 2	ompleted by	- paraparesis							auto perfe	psy ormed?	prior to		f cause of
ţ	iclan: Th certificate ector, pag	e C	25. Was case referred to medical					26. Pla	ce of Death	1 ☐ Yes	2 2 No	11.116	s 211 No	
>		To B	examiner? 1 ☐ Yes 2 1 No	Hospital: 1 Inpatie	nt 2 🗆 i	ER/Outpatie	nt 3 DOA		Nursing Ho	me 5□Resi	dence 6	Other (Sp	ecify)	
Division of	ing Pl		27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	W	jury at /ork? □ Yes 2[_/	28d. Describe	how injury	occurred /		
<u>s</u>	Attanding ir death. actor: After by the fune	lcat	2 Accident investigation M							28f. Location (Street and	eet and Number or Rural Route Number,		
<u>≤</u>	al or A s after il Dira	Certification:	4 Homicide determined determined 4 Homicide determined 4 Homicide 288. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)									various of flatal floate flation,		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Diractor: After this completely filled in by the funeral di	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	/sicien: To the best of iner: On the basis of and manner sta	examinat	wledge, deat ion and/or in	th occurred at the	time, date y opinion, d	and place, eath occurr	and due to the ed at the time,	cause(s) date and	and manner a	as stated. ue to the cause	Θ(S)
	To tha within 2 To the comple	Me	29b. Signature and title of certifier				29c. Lice	nse numbe	r		29d. Date	signed (Mo	nth, Day, Year	.)
	0	/	1 fi E. Kuh	m			MD	309	46		Dec	ember	21,20	04
1	1-1		30. Name and address of person who o	completed cause of d	eath (Item	23a) (Type	Print)	0.1	0 1	112 2	\ D	200	1-7	
	21		31. Date filed (Month, Day, Year)	Lun, M.I.	ノ・ (q r's Signat	ure	introse	Kd. I	COCK	ville, 1	M	208	フム	
	Sta Registi			Bure	K	Soul	es .							
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DHMH 17 Rev 1/2001

ORIGINAL

			State of Ma	ryland / Depa		Health and Mental Hy	-	4 4 1897
	Physic /Med Exami	ical	1. Decedent's Name (First, Middle, Last) AUDREY NAOM 4a. Fecility Name (If not institution, give street and number) HARBOR HOSPITAL	LESTER		2. Date of D Month DECEMO or Location of Death 10 RE / MARYLAG	Day Year BER 31 2004 4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sex 7. Age 212-28-1005 1 M 2 AF	(In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	Hours Min. (Month, D	irth 9. Bir	rthplace (State or Foreign ountry) Maryland
	death with the Maryland ms 23a or 28a-f show r must be mailfied at	ector	10a. State 10b. County MD N/A 10e. Street and Number	10c. City, Town or Lo	Baltim	ore		10d. Inside City Limits ↑ Yes 2 No
	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Modical Examiner must be nutified at ODGs.	Funeral Director	2437 Harriet Avenue 11. Marital Status 12. Was Decedent E- Armed Forces?			21230 dispanic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.)	10g. Citizen of What C United Sta o- 14. Race - Am Black, Whi	ates encan Indian,
5-0036	72 hours afte natural', or I	sted by Fi	1 Never Married	16a. Dece	1 ☐ Yes 2X No	Specify:	Specify:Whi	lte
Maryland 21215-0036	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r traumatic event, Ira Mad	e Completed by	Elementary/Secondary (0-12) College (1-4or 5+ 8 17. Father's Name (First, Middle, Last))	memaker	during most of working d) 18. Mother's Name (First, Middle	Own H	Iome
larylan	2 should be and Mental Is marked c	To Be	James Dalziel 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	Margaret and Number or Rural Route Numb	Nesbitt	Zip Code)
Baltimore, N	ages 1 and sont of Health t: If Item 27 y or other tr			120b. Place of Dispo Meadowrid	sition (Name of patory or other plac	Date	20c. Location - City or	
Baltir	permit. F Departme Importan any injur	(21. Signatur Funeral School London	Memorial 22 27	. Name and Addre	1-5-2005 ss of FacilityAmbrose Fu ads Ferry Rd., L	Elkridge, neal Home, ansdowne, M	Inc.
	Physician /Medical Examiner		Due to (or as a	ne death. Do not enter WELOI consequence of):	er the mode of dyin BミヤRい	g, such as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
8760,	sate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	TASTAT consequence of): DRONAR consequence of):		TERY DISEA		YEARS.
P.O. Box 68	The law requires that the death certificate that been signed by the attending phy page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
Records, F	e law requires tha has been signed l je 2 should be det	Completed by P	Part II. Other significant conditions contributing to death but RENAL FAILURE /H			NEARCTIC 1 24a. Was	an 24b. Were au	obably 4 Unknown
Vital	ysician: The is certificate hadirector, page	o Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient	2 ☐ ER/Outpatient	3 DOA Othe	1 ☐ Yes 26. Place of Death (Check only of	ormed? death? 2 \(\) \(
Division of	anding Ph ath. or: After th	Certification; T	27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation investigation	'ear) 28b. Time of Injury	28c. Injury Work M 1	rat 28d. Describe 7.7 res 2 \(\subseteq No	how injury occurred	
Div	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined 256. Place or injury building, etc.	ny knowledge death	occurred at the tim	City or Tou	gauss(s) and manner on	atatad
į	To the Ho within 24 To the Fu completel	Medical	(Check only one) 2□ Medical Examiner: On the basis of exand manner state 29b. Signature and title of certifier Binolu \$\frac{1}{2}\$. INTE	d.	estigation, in my op	pinion, death occurred at the time,	date and place, and due 29d. Date signed (Month)	to the cause(s)
Ц	No The State of th		30. Name and address of person who completed cause of dea BINDU KANAPURU 300	th (Item 23a) (Type, F	Print) ERST	-	MD, 212	25
ľ	Sta Registr	te	31. Date filed (Month, Day, Year) 32. registrar's JAN 0 5 2005	Signature	orde)			

DHMH 17 Rev 1/2001

04-08307 WAYNE LONG WHM

			For State Registrar	State of r	naryland /	Depa <i>Cei</i>	artment of H <i>tificate of L</i>	ealth and M D <i>eath</i>		iene [] []	4 41898
	Physici	an	1. Decedent's Name (First, Middl			-			2. Date of Deat	n Day	3. Time of Death
1	/Media	al	Wayne Long 4a. Facility Name (If not institution				Ab City Town	Location of Death	DECEMBE	324,20	004 7:35 P M
	Examir	er	2108 S. BOSTON	STREET APT	606			ORE CITY		4c. County of	Death
	Funeral Director		5. Social Security Number 100-91-2542		Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 19,		9. Birthplace (State or Foreign Country)
	σ	}	Usual Residence of Decedent						reu 19,	1942 11	laryland
	death with the Maryland me 23a or 28a-f show rriust be notified at	tor	10a. State 10b. County	,	10c. City, Tov	m or Lo 1 ti m					10d. Inside City Limits 1 Yes 2 □ No
	th the	lrec	10e. Street and Number				10f. Zîp Code		10	g. Citizen of Wh	at Country?
	ath wi	rai	2108 Boston S					21231		USA	
920	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 ie marked other then "natural", or iteme 23a or 28a-f show other treumatic event, the Madical Exartinar trust by notified at	I by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar. 3 □ Widowed 4 🏋 Divorced	If Yes Give	s? ∃ ^{No} un]	k l	Vas Decedent of Hi f Yes, specify Cubai I ☐ Yes 2X No	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
5-0	natu	letec	15. Deceden (Specify only highe	nt's Education est grade completed)	16a	. Deced	lent's Usual Occupa kind of work done o OO NOT use retired,	ition Juring most of worki	unk unk	6b. Kind of Busi	ness/Industry unk
Maryland 21215-0036	e filed within al Hygiene. I other then vent, the Max	Completed by	Elementary/Secondary (0-12) 12	College (1-4d	r 5+)	iife. L	OO NOT use retired,				
pu	be filed tal Hygi d other event, L	Be	17. Father's Name (First, Middle,					18. Mother's Name		faiden Surname)	
7	2 should be f and Mental I le marked of reumatic eve	2	Milton W. 19a. Informant's Name/Relations		19	h Mailin	g Address (Street a		Becker	City or Town SI	tate Zin Code)
	nd 2 salth an 27 ie		Laura Shanholt								FL 33322
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☑ Other (S	3 □Removal from⊾Sta	20b. Place of comete	of Dispo ery, cren	sition (Name of natory or other place	9)	Date 2	oc. Location - C	ity or Town, State
Balti	permit. Departnimporte any inju		21. Si matuju of Euneral Service	Licensee //	rector	St Ba	Name and Address ate Anato Itimore,	s of Facility Dmy Board MD 2120	655 W.	Baltimo	re Street
	Physician /Medical		23a. Part1. Enter the disease, or snock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	ARTERIOS	line.	C CA	er the mode of dying	g, such as cardiac c	n respiratory arre	st,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	b							
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Lue to (or a	as a consequençe	of):					
68760,	eath certificate be executed attending physician and for use as the burial-transit	al Exa	resulting in death) Last	Due to (or a	as a consequence	of):					
	tificate ng phy as the	ledical		u							
.O. Box	requires that the death cer een signed by the attendin nould be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death		Ectopic pregnancy Other (specify)			23d. Date of Month	
4	uires that signed b Id be deta		Part II. Other significant condition	ons contributing to death	but not resulting	in the ur	iderlying cause give	n in Part I.			ute to the cause of death?
Vital Records,	e law has b	Completed by							24a. Was an autopsy perform	ed? prid	ore autopsy findings available or to completion of cause of atth?
/ita	Physicien: The this certificate al director, pag	Be	25. Was case referred to medica examiner?					26. Place of Death	(Check only one)	
of	Sis	5.	1- Yes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpa 28a. Date of Ir		utpatien: Time of	3 DOA Othe	f: 4 ☐ Nursing Hor	me 5 Resider 28d. Describe hov		(Specify) SCENE
ion	nding th, r: After e fune	ation	1X Natural 5 ☐ Pendir 2 ☐ Accident investi	ng (Month, I		Injury	Work	?` 'es 2 □ No	Edd. Booding 1101	v arjury occurred	
Division of	after dea Director	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of I	njury - At home, fa etc. <i>(Specify)</i>	arm, stre	eel, factory, office	-	28f. Location (Str. City or Town,	eet and Number State)	or Rural Route Number,
_	To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After it completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifyir Certifyir Certifyir	ng Physician: To the be Exeminer: On the basis and manner	of examination ar	e, death	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ca	use(s) and mann te and place, and	er as stated. If due to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifie	" Mey	rule	MV	29c. License	number C M E			Month, Day, Year) 25, 2004
			30. Name and address of person MARGARITA KORE		f death (Item 23a)			TREET, BA	ALTIMORE	, MARYLA	ND, 21201
	Sta Registr		31. Date filed (Month, Day, Year)	5 2005 32. R	strar's Signature	63	and				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death o Physician Month Day Ruth D. Lauer December 29 2004 1:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 804 Coxswain Way Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2X F Director 578-18-9795 Yrs. 8-25-1919 Washington, DC Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location rthan "neturel", or Items 23e or 28e-f show the Mudical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Coxswain Way Funeral 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 γ 1 ☐ Yes 2 ▼No Specify: 3 √Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) year Homemaker other Home it of Health and Mental Hygi if item 27 is marked other or other treumatic event. 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filt tment of Health and Mental Hi tent: If item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Jefferson Dixon 2 Frances Ruth Fenton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth L. Wilson/ Daughter 34 Austin Drive, Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Department of Importent: If any Injury or * 4 Donation 5 Dother (Specify) Ft. Lincoln Cemetery 1-8-05 Brentwood, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licensee Mala Molles 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician malignant years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death Month Day Year 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2UNNo 1 🗌 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' 1 ☐ Yes 2 No 27. Manner of Pean Cther: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Pescribe how injury occurred After 1 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00059173 Charrer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen Kemmer, M.D. 900 Bestgate Rd., Annapolis, MD 21401

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 5

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** essie Moore 8:00P M 29 900 /Medical 4a. Facility Name (If not institution, give street and number)
School Hophins Boy Siews Conte 4b. City, Town, or Location of Death 4c. County of Death Examiner Balhnore, Marylor southnone Cit If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 5. Social Security Number Birthplace (State or Fereign Country) 7. Age (In vrs. last birthday) **Funeral** March 20, 1920 1 □ M 2 🛛 F Days Hours 214-40-8883 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Middles Examiner must be notified at MD **Baltimore** Baltimore 1 XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21224 3215 Fast Fairmont Ave. USA Itams 23a death Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Importent: if tiem 27 le markad other then 9 leny injury or other traum—". 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 🛣 No Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Castle Stella Smith ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 9249 Baltimore, MD 21222 Stella Miller / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ★Removal from State 4/05 Lawson Confederate Cemetery Cate City, VA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc 1501 East Fort Ave. Baltimore Md 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician trobushino disease or condition resulting in death) /Medical Due to (or as a conse uence of): Examiner 2, EUD LOUP 12 Sequentially list conditions, Examiner n any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Vear 4 Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate Atial Fibrillat 2 No Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospitel or Attending Physicien: within 24 hours after death To the Funerel Director: completely

> State Registrar

15

31. Date filed (Month, Day, Year) JAN 0

one)

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regi**gr**ar's Signature 5 2005

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of ertificate of		Mental Hygier	000	1. 1.100
	hysici /Medi		1. Decedent's Name (First, Middle Earl			Ma	kel/	2. Date of Death	Day Yes	1 11 115 6 11
Fu	xamir neral ector	er	4a. Facility Name (If not institution, The Johns H 5. Social Security Number 219–52–7513	opkins +	Age (In Vrs. last birthday, 55 Yrs.	Bauti			4c. County of Di	5/1
yland	Mon.		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
e Mar	ified Liffe	ctor	Md NA	A.	Balt	imore				1 X Yes 2 □ No
ith th	2 2	Dire	10e, Street and Number			10f, Zip Code		10g. (Citizen of What	Country?
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Maryland d 2 should be file th and Mental Hy	ie ve	Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	e (First, Middle, Maide	n Sumame)	
Aarylanc 2 should be f and Mental F is marked of	metic	L _O	Earl 19a. Informant's Name/Relationshi	in (Type Print)	Makell	ng Address /Street	Alma	al Route Number, City	Joh	nson
altimore, Mamil. Pages 1 and 2: partment of Health at portent: if item 27 is	or other treu		Roxanne Makell 20a. Method of Disposition 1 □ Burial 2 Coremation	Wif 3 □Removal from Sta	e 1520 20b. Place of Dispo cemetery, crer	O Gorsuch esition (Name of matory or other pla	Ave. ,_B	altimore, Date 20c.	Md 21 Location - City of	218 or Town, State
Baltimo permit. Page Department o	eny injury once.	1	* 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service □		Greenmon		1-5-	05 B	altimor	e, Md.
Balti permit. Departin	eny ir		Arany	1 Few		Name and Address March F.H	I. East	1101 E.	timore, North A	
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ords aquire en sig	should b	edt	hepatitis C,	intravenous	drug a	buse		1 ☐ Yes 2	□No 3□P	robably 4 Munknown
The The	page 2	Completed						24a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of
OT VITA Physicien:	irector,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2★No	Hospital:	0.555	Othe	26. Place of Death			
E E P	meral o	-	27. Manner of Death 1. SNatural 5 Pending 2 Accident investigat	28a. Date of In (Month, D	jury 28b. Time of	28c. Injun Warl	y at 2	ne 5 ☐ Residence 8d. Describe how inju		əcify)
UNISIO To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A	illed in by		3 Suicide 6 Could no determine	ed 286. Place of In	njury - At home, farm, stre etc. <i>(Specify)</i>			8f. Location (Street ar City or Town, State)	
the Hos hin 24 ho the Fund	mpletely	ledic	one)	Physicien: To the bes aminer: On the basis and manner s	t of my knowledge, death of examination and/or invitated.	estigation, in my op	pinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as I place, and due	s stated. e to the cause(s)
Twitter To	9	Σ	29b. Signature and title of certifier	44.0	24 0	29c. License			te signed (Mont	
/1 /		1		7, M.D., P		RES.	-000	Dece	mber 2	9,2004
21			30. Name and address of person when Michael Levy John 31. Date filed (Month, Day, Year)				o North W	holfe Street,	Baltimor	e, MD, 21287
Re	Stat gistra	e r	1AN	0 5 200F	Massace M.	Goals?				

			1 - For State Registrer	State of Ma		epartme Certifica			Mental Hy	/giene	,	
			Registrer 1. Decedent's Name (First, Middle, La	ast)				Jean	2. Date of D		20114	3 Time of Death
	Physici /Medi		RALPH W	ALKER	M	1c Dow	ELL I	I	DECEMBO	Dav	Year 2004	11:05 AM
	Examir		4a. Facility Name (If not institution, gire			4b. Ci	y, Town, or	Location of Deat			County of Death	
			THE JOHNS HOPKINS 5. Social Security Number 6.3	HOSPITAL			er 1 Year					
	Funeral Director		575-52-4695	Sex 7. Age 1 X M 2 □ F	(In yrs. last birtl	rs. Month		If Under 24 Hrs. Hours Min.	(Month, D	ay, Year)	Cour	lace <i>(State or Foreign</i> htry) sylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
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	or 28	Director	10e. Street and Number				ip Code			10g. Citiz	zen of What Cour	ntry?
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, the Medical Examinational to mailified at once.	by Funeral	Never Married 2 Married Widowed 4 ⊠ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:			edent of Hi ecify Cuba 2 🕅 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		14. Race - Americ Black, White, (etc.
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Ž	should nd Me mark matic	ပ	Dean Noyes McDow 19a. Informant's Name/Relationship		19h	Mailing Addre	e (Stroot a	Mary Be		- Ch	Town, State, Zip	0.41
	nd 2 salth ar 27 is		Melanie McDowell	**							PA 18704	
ore,	es 1 a of Hei		20a. Method of Disposition		20b. Place of I	Disposition (N	me of		Date		cation - City or To	
Baltimore,	Page ment tant: It		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special Control of the C	Hemoval from State (y)	Asbury Method	ist Chu	rch Ce	emetéry 20		Nokes	sville,	Virginia
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			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused to one cause on each line	he death. Do no	ot enter the me	de of dying	, such as cardiac	or respiratory a	ırre <i>s</i> t,		Approximate Interval Between
	Prysician	4	Immediate Cause (Final disease or condition resulting in death)	a. GRAFT	VERSUS	HOST	Dise	∆S€			3	Onset and Death
	/Medical Examiner		resulting in dealtr)	Due to (or as a	consequence of):						
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	certific Iding p	/Me	IF FEMALE:	23c. If yes, outcome o	f pregnancy					T.,		
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	s that ned b e deta	by PI	Part II. Other significant conditions	ontributing to death but	not resulting in t	he underlying	cause give	n in Part I.	23e. Did t	obacco us	e contribute to the	e cause of death?
ğ	w require been sig should b	ted t							1 🗆 '	Yes 2 🗵	Ño 3□Proba	ably 4 🗆 Unknown
l Records,	The law rate has be page 2 shi	Completed							24a. Was auto perfo 1 Yes	osy rmed?	prior to com death?	sy findings available ipletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Deal			10103	23.10
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Division of	Attanding P death. ctor: After I y the funera	ation	27. Manner of Death 1 ★ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) 28b. Tin Inji	ne of ury M	28c. Injury Work 1 Y	at ? es 2 □ No	28d. Describe	how injury	occurred	
ž N	or /	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, fam (Specify)	n, street, facto	y, office		28f. Location (a City or Tox		Number or Rural	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysicien: To the best of niner: On the basis of e and manner state	xamination and/	death occurre or investigatio	at the time	e, date and place, nion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as sta place, and due to	ited. the cause(s)
	To tha within 2 To the complet	×	29b Signature and title oncertifier			29	c. License	number		29d. Date	signed (Month, D	ay, Year)
. /	1		Javid 6	erlin MD			006	2144	Ţ.	DECEM	1BER 29,	2004
1) (DAVID GERBER, MD	JOHNS HOPKI	NS HOSPITA		NORTH	WOLFE ST	REET	BALTI	MORE, MD	21287
	Sta Registra		JAN 0 5 200	5 Persent	s Signature	rede						-

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	Physici	an	1. Decedent's Name (First, Middle, I	.ast)							2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Elijah Maye								Decembe	r 30,	2004	5:10 p M
	Examin	ier	4a. Facility Name (If not institution, g Crescent Cities		*				Location of	of Death			nty of Death	C
	Funeral				ige (In yrs. last b	irthday)	If Under		If Under	24 Hrs.	8. Date of Birth			Geroge's
	Director		246-30-0066 Usual Residence of Decedent	1⊠M 2□F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 8/10/19	Year) 24	Nort	place (State or Foreign ontry) The Carolina
	ryland how		10a. State 10b. County		10c. City, To									10d. Inside City Limits
	e Ma Sa-f s	ctol	Maryland Prince	George's	Нуа	atts	ville						1	to Yes 2 □ No
	or 2	Director	10e. Street and Number				10f. Zip				10	g. Citizen o	of What Cou	ntry?
	s 23s	rai	5805 42nd Aven					207					SA	
36	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "naturel", or items 23a or 28a-f show evant, the Medical Examber out the modified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	;? ⊈No	- 1	Was Deced If Yes, spec 1 ☐ Yes 2				ecify Yes or No- Rican, etc.)		ace - Americ lack, White, cify: B1	
Maryland 21215-0036	2 hou	ed	15. Decedent's	Education		a. Dece	dent's Usua	I Occupa	ation			6b. Kind of	Business/In	dustry
215	within 72 ene. than "na ne Medi	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4o		(Give	kind of wor DO NOT us	k done d	luring mos	t of work	ing	00. 10.10 01	Du31110334111	dustry
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yla	should be ind Mental imarked o	L _o	Henry Maye								Perkins			
<u>lar</u>	2 sh and is m raum		19a. Informant's Name/Relationship		19						al Route Number,			
e)	1 and 1ealth im 27 ther t		Dorothy L. Maye	- Wite	20h Blace									MD 20787
Baltimore,	to to the state of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3										n - City or To	own, State
Ξį	it. Pa		* 4 □ Donation 5 □ Other (Special Control of Fig. 1) Other (Special Control of Fig. 1) Other (Special Control of Fig. 2)		Counc				J	an.	8,2005	Bethe	1, NC	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic events.		21. Signature of Partial Sewice City	1/sers							sch's Fu			
			23a. Part1. Enter the disease, or co	mplications that cause	ed the death. Do						ue, Hya		le, M	D 20/81 Approximate
3	Pnysician :	5	Immediate Cause (Final	y one cause on each	line.									Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	- 77	osclerot s a consequence		carai	ovas	cular	: D18	sease			
	Examiner			0										
-	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence	of):								
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	rate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	s a consequence	of):								
87		Physician/Medical		d										
9 X	res that the death certific igned by the attending p be detached for use as	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy									
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		Ectopic pre						ate of delive Month	ory Day Year
P.O.		nysi	1 Yes 2 No	9□ Unknown			, ouror (ope							
	law requires that the as been signed by th 2. should be detache	by P	Part II. Other significant conditions	contributing to death	but not resulting	in the ur	nderlying ca	use give	n in Part !.		23e. Did toba	acco use co	ntribute to th	e cause of death?
Ď	w require been sig should b	edb									1 🗆 Yes	2 🗆 No	3 🗌 Prob	ably 4X Unknown
Vital Records,	aw requas been 2 shoul	Completed									24a. Was an	24b	. Were auto	psy findings available
Ě	The ate h	E O									autopsy perform		death?	npletion of cause of
ita ita	ysician: The is certificate hadrector, page	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only one			
of \	Physic this co	၉	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpat					44(2) (40)	rsing Hor	ne 5 🗆 Resider	ice 6 🗆 O	ther (Specify	')
n o	Attending Physician: r death. actor: After this certifics by the funeral director,	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b.	Time of Injury		lc. Injury Work			28d. Describe how	v injury occi	urred	
Sic	ttend death stor: , the f	icat	2 Accident investigate 3 Suicide 6 Could not	he			M		es 2 🗆 N		201			
ā	or Atten after deat Diractor: in by the	ertif	4 Homicide determine	d 286. Place of Ir building, e	njury - At home, f tc. <i>(Specify)</i>	arm, stre	et, factory,	office		4	28f. Location (Stre City or Town,	et and Nun State)	iber or Rura	l Route Number,
_	Hospital 24 hours a Funeral I		29a, Certifier 1X Certifying F	hysician: To the bes	t of my knowledg	e death	occurred a	t the time	o data and	d plane a	and due to the cou	100/n) and n		
	e Ho: 24 h Fur letely	edical	(Check only 2 Medicel Ext	iminer: On the basis and manner s	of examination ar	nd/or inv	estigation,	in my opi	inion, deat	h occurre	ed at the time, dat	e and place	, and due to	the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	0 0)	(29c.	License	number		29	d. Date sign	ed (Month, I	Day, Year)
		2	Shul	linle	Vore	2 Li	4	D018	352		D	ecemb	er 31,	2004
9	11		30. Name and address of person who Paul DeVore, MD	completed cause of				tev	i11a	MD	20781			,
	Stat Registra	te ar	31. Date filed (Month, Day, Year) JAN 0 5 20	2. Regist	rar's Signature	boss	ke	- C O V -		ТПЛ	20/01			

		•	1 - For State Registrar	State of Ma	arylan		artment of F tificate of		d Mental Hyg	giene 20	04 4190	L
	Physici /Medic	-	1. Decedent's Name (First, Middle, Las Christopher	t)		M	iller		2. Date of Dea December	ath r 28, 200	3. Time of Death 10:30 A	vI
	Examir	er	4a. Facility Name (If not institution, give Southern Maryland	Hospital			4b. City, Town, o	n			George's	
	Funeral Director		5. Social Security Number 250-20-0343 6. Social Residence of Decedent	9X 7. Age	84 (In yrs. 1	(ast birthday) Yrs.	Il Under 1 Year Months Days	If Under 24 I	Ain (Month, Da	v. Year)	9. Birthplace (State or Foreig Country) South Carolin	
	Maryland a-f show	tor	10a. State 10b. County Maryland Prince G	eorge's		y, Town or Lo	cation hington				10d. Inside City Limit:	
	h with the 23a or 28	Funeral Director	10e. Street and Number 10602 Cannonview	Court			10f. Zip Code 20	744		10g. Citizen of Wh	hat Country? USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "neturel", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examinar must be neitlisd at ance.	by	11. Marital Status 1 Never Married 2KMarried 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ X II Yes, Give Year or Dates:			Was Decedent of H I Yes, specify Cub I ☐ Yes 21☐XNo	dispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race Black,	- American Indian, , White, etc. Black	
Maryland 21215-0036	i within 72 ho lene. r than "natur the Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	+)	(Give	tent's Usual Occup kind of work done DO NOT use retire TY WORKE	during most of	working	16b. Kind of Busi Private	iness/Industry Industry	
/land	uld be fited Mental Hyg irked otheric event,	To Be C	17. Father's Name (First, Middle, Last) George Miller						Name (First, Middle, .ces Willia)	
	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (Tamara Miller / D		1	10602	Cannonv			sh., Mary	yland 20744	
Baltimore,	Pages 1 ment of H hant: if Itel		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	2	C	emetery, crer 1as Cr	sition (Name of natory or other pla- ematory	12/.		Edgewater	city or Town, State r, Maryland	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licer	Swan		6	160 Oxon	Hill K		Hill, Mai	Home P.A. ryland 20745	
8760,	Physician / Medical Examiner physician up ph	dical Examiner	23a. Part1. Enter the disease, or composition of the control of th	one cause on each iir	a conseq	uence of):	mbolism	^	May May	1001,	Interval Between Onset and Death 7 WWW	
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and orge 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. II yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fete	Ideath 3□	Ectopic pregnanc	у		23d. Date Mont	ol delivery th Day Year	
	quires that n signed by	by	Part II. Other significant conditions of	ontributing to death b	ut not res	ulting in the u	nderlying cause giv	ven in Part I.		obacco use contrib res 2 No 3	bute to the cause of death? 3 ☐ Probably 4 ☐ Unknow	'n
Reco		Completed					,		24a. Was autop perfo	osy pri rmed? de	fere autopsy findings available for to completion of cause of sath? Yes 2 No	le
Vita	Physician: The lithis certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:			Ott	10r	Death (Check only o			_
of	유 무 등	5	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date of Inju		ER/Outpatier 28b. Time of	1 3U DOA	4	ng Home 5 ☐ Resid	dence 6 Other		
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	1	(Month, Day	y Year) ury - At he	Injury ome, larm, str	Wo	rk? Yes 2 □ No		Street and Number	r or Rural Route Number,	
J	Hospital of 24 hours all Funeral Dietely filled i	Medical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of the basis of and manner sta	examina	owledge, death	n occurred at the fivestigation, in my o	me, date and p opinion, death o	lace, and due to the occurred at the time,	cause(s) and mani date and place, ar	ner as stated. nd due to the cause(s)	
)	within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens				(Month, Day, Year)	
f			30. Name and address of person who Michael Sida 2	completed cause of d	eath (Item	n 23a) (Type,	Print)	# 101	1ft 64	rligtan	m2 20761	-
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra		iture	all t					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** <u>Marguerite Murphy McClellan</u> /Medical Dec. 16 2004 1745 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace
If Under 1 Year | If Under 24 Hrs. Harford 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Months Days Hours Min. Yrs. 85 Director 218-12-2074 10/20/1919 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other then "netural", or Items 23a or 28e-f show treumetic event. It e Madical Examiner mast be notified as 1 Yes 2 □ No Directo MD Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Deaver St. Funeral 21078 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 is marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) 11th **U.S Government** <u>Time Keeper</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ezekiel Murphy Vandila Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2 sh Department of Health and Importent: If item 27 is rr any injury or other treum once. Anna M. Gall- Executor 710 S. Stokes St., Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Grove Pres. Ch. Cem. 12/20/04 | Aberdeen, MD Signature of Funeral Service Licensee Miltchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 (23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine IF FEMALE 23c. If yes, outcome 1 Live birth e of pregnancy 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 Yo 24a. Was an 1 ☐ Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yøs 2 W No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) in by the funeral 27. May er of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 C uld not be etermined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 64 gause of death (Item 23a) (Typ

DHMH 17 Rev 1/2001

State

Registrar

d (Month, Day,

Year)

JAN 0 5 2005

			1 - For State Registrar	State of Maryla	and / Depa	artment of Hertificate of D	ealth and M	lental Hy		001.	4, 1	0 N E
	_		Decedent's Name (First, Middle, Last,)		timeate of E	zeatri .	2. Date of Dea		000	3. Time o	JUO f Death
	Physic			OLA MULCAHE	v			Month	Day	Year		
	/Medi Examir		4a. Facility Name (If not institution, give		J.L	4b. City, Town, or	Location of Death	Decembe		ounty of Death	4:30	A ^M
	LXamii	ici	Frederick Memorial	l Hospital		Frederic				ederick		
	Funeral		5. Social Security Number 6. Se:	x 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1		place (State ontry)	or Foreign
	Director		217-18-8237	M 2₹F 8	1 Yrs.	Months Days	Hours Min.	(Month, Day Jan. 4,	1923 (1923	3 Mary	ntry) Land	
	pu >		Usual Residence of Decedent 10a. State 10b. County	10-	01. T					•		
	aryla ehov	-			City, Town or Lo	ocation					10d. Inside C	•
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	with 1	Ē	10e. Street and Number	1 1		10f. Zip Code				on of What Cou	ntry?	
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	ter d	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No	10.5.	Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	14	I. Race - Ameri Black, White,		
336	ors at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🏋 No	Specify:		S	Specify: Whi	to	
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2	filed with Hygiene. othar thai	5	12		owner,	operator			restu	iarant/	hospit	ality
nd	al Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Si	umame)	•	
<u>V</u>	should ba ind Mental i marked o umatic eve		Benjamin Basil Biel	11		M	lacy E. E	yler				
Maryland	and and is m		19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street ar	nd Number or Rura	i Route Numbe	r, City or 1	own, State, Zij	o Code)	
	1 and 2 Health tem 27		Nancy Mulcahey, dau		6388 T	Vinchester	Avenue,					25438
9			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	lemoval from State	cemetery, crei	sition (Name of natory or other place	12/3	1/2004		ation - City or To		
Ë	nit. Parantmen ortant: injury		' 4 ☐ Donation 5 ☐ Other (Specify)	M		Haugh's L						
Baltimore,	parmit. Page Department of Important: if eny injury or 2009.		21. Signature of Fineral Service Litera)	00999 10	Name and Address East Ch	of Facility Kee:	ney and	Basf ederi	ord Fu	neral 1 2170	
	F - 1		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the de	ath. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arr	est,	.010	Approximat Interval Bet	
8	Priysician		tmmediate Cause (Final disease or condition	Due to (or as a cons ADENS CARC	ASTASE	8					Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):	-C 211	000			- 4	2010	^ 4
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	ad	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	aquarica ot).							
	ate be executad hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	equence of):							
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687	icate phys			J								
Box (eath certific attending p for use as	Physician/Med	IF FEMALE:	3c. If yes, outcome of pred	nancy				22	d. Date of delive	201	
B	atter affor u	ciar	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3	Ectopic pregnancy Other (specify)			230	Month		Year
P.O.	at the de by the a tached	lys	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown								
ري ح	res that ignad b	by Pl	Part II. Other significant conditions cor			nderlying cause giver	n in Part I.	23e. Did to	bacco use	contribute to t	he cause of d	leath?
ords	w require been sig should b	ted b	PRIMARY BILLARY					1 □ Y	as 2 🔀	No 3 ☐ Prot	ably 4 🗆	Jnknown
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Vital	Attending Physicien: 3 r death. ector: After this certifical oy the funeral director, p	Be	25. Was case referred to medical examiner?	fospital:		0.1	26. Place of Death					
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Division	I or Attendi after death. Director: A I in by the fu	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	home farm str			28f. Location (St	reet and N	Number or Rue	al Route Num	her
D	of the c	Certification:	4 Homicide determined	building, etc. (Spe	cify)	out ractory, office		City or Town	n, State)	70111001 OF 71010	11710018 7401711	Jer,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	Check only 2 Medical Exemit	sicien: To the best of my k	nowledge, death	occurred at the time restigation, in my opin	, date and place, a nion, death occurre	and due to the ca	ause(s) an	nd manner as s ace, and due to	tated.)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				signed (Month,		
	H S H Ö	/	> Beand 19Con	an Suc		031				129/09		
1	10		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Tyne	Print)			, ,	101/09		
7	0"		BRIAN M. O'CONN	or ms st	1/ W. S	EVENTH	51.	FREDER	1 CK	MD	2170	/
	Sta Registr		JAN 0 5 200	mpleted cause of death (It ON MA 57 32 Registrar's Sig	b for	de						

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Dey 22, 2004 Month **Physician** 3:25 AM John J. Nigl /Medical 4b. City, Town, or Locetion of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Parkville Baltimore Oak Crest Village if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Dec 14, 1913 9. Birthplace (State or Foreign 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Hours Mary Land Yrs. 91 215-05-9144 Director Usuel Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner nust be notified at 1 ☐ Yes 2 🗓 No Parkville MD Baltimore Funeral Director 10g, Citizen of Whet Country? 10e Street and Number 10f Zin Code ò 21234 USA 8830 Walther Blvd or items 23a 12. Was Decedent Ever in U,S. Armed Forces? 1-12 Yes 2 □ No If Yes, Give Yeer or Dates: 42-4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: white Specify: Completed by 42-45 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed within 7 el Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) distributor petroleum 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) should be fi end Mente Mamie Elizabeth Gunter John J. Nigl 19b. Maiting Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health end Important: If Item 27 Is m. 19a. Informant's Name/Relationship (Type, Print) Carolyn Fiege/niece 9231 Harford View Drive Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ò 4 X Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Fecility State Anatomy Board 655 W. Baltimore Street any ir Director Baltimore, MD 21201 olitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Intervat Between Onset and Death Part1. Enter the disee e, or co shock, or heart failure. List only **Physician** Immediate Cause (Finat disease or condition resulting in deeth) /Medical 10years Parkinson's Examiner Due to (or as a consequence of) Examiner ettending physician and for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medicai Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown homic Obs Nuctive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed TE Yes 20€ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → Medicai Certification: To After this filled in by the funeral 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 5 Pending investigation 1.□Natural 1 ☐ Yes 2 ☐ No efter death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 27, 2004 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Nather Blod Bullmore MD 21234 WILLIAM nu MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2005 Registrar

DHMH 16 Rev 6/95

Physician	,	1. Decedent's Name (First, Middle Gregory 0 C					2. Date of De Month DEC	_Day _	Year	3. Time of Death
/Medical Examiner	1 -	4a. Facility Name (If not institution 401 EAST 25th			4b. City, Town, or I)()4 nty of Death	0902 A
Funeral Director		5. Social Security Number \overline{unk}	6. Sex 7. Age (In yrs			ORE CITY If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec 18,	v. Year)	9. Birthp	place (State or Foreintry) un
f show		Usual Residence of Decedent 10a. State 10b. County MD	10c. C	ity, Town or Ba	Location altimore				1	0d. Inside City Limi
3a or 28a-f st st be notified al Director		10e. Street and Number 401 E. 25th St	reet		10f. Zip Code	21218		10g. Citizen o	of What Cour	•
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Modical Examiliner must be notified at once. To Be Completed by Funeral Director	Dy ruitel	11. Marital Status U 1 Never Married 2 Marria 3 Widowed 4 Divorced	If Yes Give	unk	8. Was Decedent of His If Yes, specify Cuban		pecify Yes or No o Rican, etc.)	Spec	ace - Amend lack, White,	can Indian,
ygiene. her than "natura it, I're Madical I	ollipicted	15. Deceden (Specify only highe Elementary/Secondary (0-12) unk	t's Education st grade completed) College (1-4or 5+) unk	16a. Dec (Giv life.	edent's Usual Occupal ve kind of work done du DO NOT use retired)	ion uring most of wor	unk _{king}	16b. Kind of	Business/Ind	dustry un
Mental Hyg arked other atic evant.	ם ב	17. Father's Name (First, Middle,	Last)		unk	18. Mother's Nan	ne (First, Middle,	Maiden Suma	ame)	u
salth and N n 27 is mailer traumailer		19a. Informant's Name/Relations O . C . M . E .		111	iling Address (Street ar				_	Code)
rtment of He rtant: If itan njury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (S	3 □Removal from State	cemetery, cr	position (Name of ematory or other place,		Date	20c. Location		
Depa Impo any ir once		21. Signature of Euneral Service	. Hade Vive to	r	22. Name and Address State Anato	my Board	655 W.	Baltin	more S	treet
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and Medical kaminer Kaminer		Immediate Quuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Atheroscler Due to (or as a consect.	otic C quence of):	nter the mode of dying,	such as cardiac	or respiratory ar			Approximate Interval Between Onset and Death
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State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) DEEMBEN Year **Physician** 3:35 AM 2004 Edna Florence Owen 22 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Cecil Elkton Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🕱 F Director 88 213-46-3161 01/26/1916 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Directo New Castle Newark 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 19713 85 Chaucer Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XNo Specify: Specify: Completed by White 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 12th Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella M. Hurley 2 Walter J. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 85 Chaucer Dr., Newark, DE 19713 Monte E. Owen- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: if Ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery | 12/28/04 Havre de Grace, MD Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, 21. Signature of Funeral Service Licensee MD 21078 P=11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TAILUME RESPINSTORY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ASPINITION PURIMONTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-transit death certificate be executed Smoll Bour OBSTNETION resulting in death) Last Due to (or as a consequence of): Physician/Medical d. as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 🏖 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes S)X No Completed EMENTIA Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HIPENTENSION has autopsy performed? page : certificate 2 🗌 No 2 No 1 Yes 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2X No After th funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the tte of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and DECOMBER 22, 2004 H53419 30. Name and address of girson who completed cause of death (Item 23a) (Type, Print) KODNEY DONARM, D.O 106 BOW STREET ELKTON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 5 2005 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Pack D. Lynnette 2004 recember /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** NA Baltimore Stella Maris Mercy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 💥 □ F Yrs. 219-19-1124 Director 33 Md. Usual Residence of Decedent 10c. City, Town or Location Show 10a. State 10b. County 10d. Inside City Limits an "natural", or Itema 23a or 28a-f shov Medical Examinar must be notified al Yes 2 □ No Director Md. NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21223 USA 606 S. Fulton Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ♥ No Specify: Black Specify: ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) art. Unemployed NΑ 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 1 and 2 should be Health and Mental White Pack Barbara Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 I 222 Sunset Dr., Glen Burnie, Md. Barbara Colbert Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. <u>=</u> ŏ Voshell Mem. Garden 1-5-05 Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. Bla Worne March F.H. East <u>1101 E. North Ave.</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acquire Immunodeficias Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending p for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. s been signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown Inapport 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 Yes Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 8 Other (Specify) NOSpice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 2 1 Tes this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after death unaral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in 24 hours a 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funa completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie)40854 2005 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST Paul Riseberg Baltimore 32. Registar's Signature 31. Date filed (Month, Day, Year) State 2005 ▶ Registrar

				State of M	arylariu /	Certificate of				Reg. No. 🥠	001	1.10.
	Physici	an	1. Decedent's Name (First, Middle, L						2. Date of Dea Month DECEMBE	ıth 🧲	U U 4	3. Figne of Death
1	/Medi		HAROLD THOMAS		-		45.0	Shr Tourn or	DECEMBE Location of Death			9:25 PM
2	Examir	ner	4a. Facility Name (If not institution, g		,		4D. C				y of Death	
	Funeral	3	LONGVIEW NURSIN 5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last	birthday) If Under 1 Ye		MANCH Under 24 Hrs.	.8 Date of Birtl	1	ARROLI 9. Birthpl	
	Director	Н.	217-12-2257	1 XX 2□ F	87	Yrs. Months Da	ys H	lours Min.	JULY 15	, 1917	MAR	lace (State or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					10	0d. Inside City Limits
	Meryl F sho	ğ	MARYLAND CARRO	LL	WES	STMINSTER						XXYes 2 □ No
	th the	Director	10e. Street end Number	~		10f. Zip Code				10g. Citizen of		-
	ath will	ral	404 FARM CREEK RO	AD			157			UNITE		
	items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces		13. Was Decedent of If Yes, specify C	of Hispa Juban, M	nic Origin? (S flexican, Puert	pecify Yes or No- o Rican, etc.)	14. Ra Bla	ce - America ck, White, e	
20	urs aff		X3√Widowed 4 □ Divorced	XXYes 2 ☐ If Yes, Give Year or Dates:	WWTT	1□Yes XXXN	No S	pecify:		Specia	^{fy:} WHIT	Œ
2 2	filed within 72 hours after death with the Meryland Hygiene. ther then "netural", or items 23e or 28e-f show int, the Meslical Examiner must be invitted at	Completed by	15. Decedent's E (Specify only highest g.			Sa. Decedent's Usual Occ	cupation	n na most of wor	kina	16b. Kind of B	lusiness/Ind	iustry
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<u>la</u>	ild be ental ked o	To Be	THOMAS PICKETT	•			C	LARA M	ABEL EYL	ER	·	
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other treumatic avent, the Medical Examinet roust be multiled at once.		19a. Informant's Name/Relationship H. NELSON PICKETT			9b. Mailing Address <i>(Stre</i>						Code)
re,	os 1 ar of Hea item 2		20a. Method of Disposition	7	come	of Disposition (Name of tery, crematory or other p	place)	1	Date	20c. Location	- City or Tov	wn, State
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Baltimore,	permit. Depertimports any inj		21. Signature of Funesal Service Lice	ensee		22. Name and Add MYERS-DUF 91 WILLIS	RBOR	AW FUN	ERAL HOM WESTMIN			157
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4	Physician					- 00					a B Line	Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a		OK N					1	Years
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Vital Records,	v require been sig	Completed							24a. Wes a perform		avai	re autopsy findings ilable prior to ipletion of cause
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ā			25. Was case referred to medical				26	Place of Dea	th (Check only on	*	10	Yes 2□ No
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o C	Attending Physician: r death. sector: After this certific by the funeral director.		27. Manner of Death 1 Natural 5 Pending	28e. Date of Inju (Month, Da	ry 28b y Year)	. Time of 28c. In Injury		=	28d. Describe ho	w injury occur	red	
DIVISION	ttendi death. tor: A	icati	2 Accident investigation 3 Suicide 6 Could not I	e no Plan et la	unz - At home	M 1 farm, street, factory, office		2 No	28f. Location (St	reet and Numb	er or Rural	Route Number
2	offer effer d in by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	rami, shoot, ractory, one	,6		City or Town			710010 710001
	To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di	edicai C		miner: On the basis of	examination e	ge, death occurred at the end/or investigetion, in my						
	o the vithin 2 on the omple	Med	29b. Signature and title of certifier	and manner sta	sted.	29c. Lice	nse nur	nber	_ 2	9d. Date signe	d (Month, P	ay, Year)
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1	0510		30. Neme end address of person who		eath (Item 23a) (Type, Print)		,				
(1		STEVEN N. SHAFFER 31. Date filed (Month, Day, Year)	00 Di-t-		KE, HAMPSTE	•	MD 21	074			
	Sta Registr		JAN	0 5 200	German	1. Agards						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician 2004 Miríam Eloise Phillips | December 9:00 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City, Town or Location of Death **Examiner** Montgomery General 01ney Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year June 16, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2Ĭ F Months Yrs 253-28-1755 86 Atlanta, Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ?7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar man be notified at 1X Yes 2 □ No Directo D.C. None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1725 K Street N.W. 20006 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Olin Phillips Corrie Hindsman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Y. Jones (Niece) 3861 King Arthur Rd. S.W. Atlanta, GA 30331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/29/04 Atlanta, GA ^¹ 4 □ Donation 5 □ Other (Specify) Lincoln Cemetery 21. Signature of Funeral Service License ²² Name and Address of Facility CAST Larking Street S.W. Atlanta, GA 50313 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMONIA DAY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cluado for as a gorsequança offi-Examiner attending physicien and for use es the burial-transit requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 9□ Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à AITWS 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Danpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tille of certifie 30. Na e and addess of person who completed cause of death (Item 23a) (Type, Print) DMELL COLNEY Mi 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 9 5 2005 Registrar

CALVERT MANOR NURSING HOME As. City Town or Location of Death C. County of Death C. C			1 - For State Registrar	State of Ma	ryland / Dep		Health and I	Mental Hyg	iene g. No. 2	004 41
CALVERT MANOR NURSING HOME CALVERT MANOR NURSING HOME Foundation			CATHERINE GRACE	PATRICK		4h City Town	ar Location of Dooth	DEC.	Day 28 20	04 10:25P
Social Security Number Sext Sex	Exami	ner			F			1		
100. Clark 100			5. Social Security Number 6. Se 10 10 10 10 10 10 10 10 10 10 10 10 10	x 7. Age	(In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	(Month, Dey,	Year)	9. Birthplace (State or For Country) Maryland
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Elementary/Secondary (o.12) College (1.4or 5+) Cashier Cas	ours after de alf, or item Executation	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 🛠 N If Yes, Give	0			o Rican, etc.)	Black	, While, etc.
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The part of the pa	iled w lygier her th			N/A		Cashier	18 Mother's Nan	ne (First Middle)		
Patricia Czemiewski (Cousin) 200. Mathod of Deposition XR Bural 2 Cliceration 3 Removal from State Commission of Faith Cem. 200. Place of Deposition (Name of County of State Place) XR Bural 2 Cliceration 5 Clother (Specify) 21. Signature of Faith Cem. 22. Name and Address of Faith Cem. 22. Name and Address of Faith Cem. 23. Same Part Address of Faith Cem. 24. Signature of Faith Cem. 25. Same and Address of Faith Cem. 26. Same and Address of Faith Cem. 27. Same and Address of Faith Cem. 28. Place of Deposition (Name of County of State Place) 29. Same and Address of Faith Cem. 20. Leaston Funeral Horne Approximate County of State Place of Deposition 20. Same and Address of Faith Cem. 21. Signature of Faith Cem. 22. Name and Address of Faith Cem. 23. Same and Address of Faith Cem. 24. Name and Address of Faith Cem. 25. Same and Address of Faith Cem. 26. Same and Address of Faith Cem. 27. Name and Address of Faith Cem. 28. Place of County of State Place of Cou	hould be fid Mental Harked of		Louis Seifert	une Print)	19h Mail	ing Address (Street	Anna Ma	ry Tremper		
Solution Committed Commi	ith and 27 is r									nate, 210 0006)
22. Name and Address of Facility Lassahn Funeral Home 7401 Relating Rd. Baltnimme, Manyland 21236 23a. Part Lene the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest. Approximation of the facility cause (Final death) Approximation death) Due to (or as a consequence of): But to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 1 FEMALE: 23b. Due to (or as a consequence of): 1 Yes 2 No 1 Yes 2 No 23d. Date of delivery. Month Day Due to (or as a consequence of): 1 Yes 2 No 23d. Date of delivery. Month Day Due to (or as a consequence of): 1 Yes 2 No 23d. Date of delivery. Month Day Due to (or as a consequence of): 23d. Date of delivery. Month Day Due to (or as a consequence of): 23d. Date of delivery. Month Day Due to (or as a consequence of): Due to (or as a consequence	~ ~ .		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or other pla	ice)			•
23a. Part I. Enter the diseased, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals and shock, or heart failure. List short was caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals the shock, or heart failure. List short was caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals the shock, or heart failure. List short was caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals the shock or heart failure. List short was a consequence of): 25b. Was decedent pregnant in the past 12 mogents? 1 Tep Male: 23b. Was decedent pregnant in the past 12 mogents? 1 Tep Male: 1 Tep M	permit. Departm Importa any inju						Ld			3
Temporary Temp	/Medical Examiner intrial-transit		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, it along to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a Due to (or as a Due to (or as a	a consequence of):	<u> </u>				Interval Between Onsel and Death
Part ii. Other significant conditions continuous of interesting in the underlying cause given in Part ii.	2 > 2		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1□Live birth 4□Pregnant at	2 Fetal death 3		у			
25. Was case referred to medical examiner? 1 Yes 2 No	quires that n signed by	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the	underlying cause gr	ven in Part I.			bule to the cause of death
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The statural solution of the statural solution	ician: sertific ector,	Be	examiner?	Hospital:		10*				
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of Certifier (Month, Day, Year)	at or Atten s after deal J Directors d in by the	ertifica	3 Suicide 6 Could not be	250. Place of inju	ry - Al home, farm, s . (Specify)	treet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	r or Rural Route Number,
29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	he Hospitu in 24 hours he Funera pletely fille		(Check only 2 Medicel Exam	iner: On the basis of	examination and/or is	th occurred at the t nvestigation, in my	me, date and place opinion, death occu	urred at the time, d	ate and place, ar	nd due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Tok headly 28/ F. Magin St, R. Sing Sun, MD 2/9//	Tor Tor	× /	29b. Signature and title of certifier	MD						/
State 31. Date filed (Month, Pay (Year) 2005 Registrar's Signature	yr.		M. Tokhada	1, 2		Megin S	t, R.s.	ing Sen	, MD	21911

DHMH 17 Rev 1/2001

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	Physici	an	Decedent's Name (First, Middle, Last)		2		2. Date of Death Month	Day Yeer	P** 00 0 14
	/Medio		4a. Facility Name (If not institution, give street and number)		KUFUS	Location of Death	DECENBER 2	4c. County of Dea	<u>-i-</u>
4	Examir	er	2829 LODGE FARM RD		BALTIMO			BALTI	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	if Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	9. Bi	rthplace (State or Foreign
	Director		251-66-3479 10M 2AF 8	79 Yrs.	Months Days	Hours Min.	APRIL I	1915 50	ountry)
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	gos 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avant, the Medical Examinar must be notified at	ctor	MARYLAND BALTIMORE		BAL	TIMOR		1/	1/€Yes 2 No
	with th a or 26 De po	Funeral Director	10e. Street and Number	Dann	10f. Zip Code	21219	10g	Citizen of What C	ountry?
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			ANIRUDH SRIDHARAN HOPKIN	S ELD	er Rus	4940	-ASTER)	VAVE	MD 21224
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AN			State of Maryland / Department of Health and M State of Maryland / Department of Health and M State of Maryland / Department of Death as	lental Hygie	ne No.2004	1.1915
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Nathaniel Russell 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of Death December		3. Time of Death 1230 PM M
799	Funeral Director	CI	2231 N. Longwood Street S. Social Security Number 6. Sex 10 Age (In yrs. last birthday) Yrs. Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day	NIA 9. Birthp Scour	ace (State or Foreign
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Baltimore, Maryland	ges 1 and 2 should be it of Health and Mental If item 27 is marked or or other treumetic eve	To Be	Nothonie Russell SR. 19a. Informant's Name/Relationship (Type, Print) EVO 50 0mon 20a. Method of Disposition 1 (Paurial 2 Cremation 3 Removal from State) 14 Donation 5 Other (Specify) 1 (Specify) 1 (Specify) Catheria 19b. Mailing Address (Street and Number or Run 231 Longwood St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 (Paurial 2 Cremation 3 Removal from State) ne Solo Balto Date 200	mon	6	
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2⊠ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated. 29b. Signature and title of certifier 29c. License number 0.C.M.E.	red at the time, date	e(s) and manner as st and place, and due to Date signed (Month, a ecember 30,	the cause(s) Day, Year)
	Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUB (O/Y) 111 Penn Street, Ba 31. Date filed (Month, Day, Year) 32. Registrar's Signature, JAN 0 5 2005	altimore,	Maryland 2	1201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RagistrAMEND TTEM #15 PER FH C839 1/05/05 JH 2. Date of Death 3. Time of Death **Physician** Year SNOWDEN 11:20 AM 2000 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ballmore
If Under 1 Year If Under 24 Hrs. Sattmal 1050121 5. Social Security Number Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 ☐ XF Director Yrs 213-32-1517 02/09/1937 Marvland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Items 23s or 28s-f show Completed by Funeral Director Maryland Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5509 Wesley Avenue 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 3 ☐ Widowed 4 ☐ Divorced Black other treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other then College (1-4or 5+) Elementary/Secondary (0-12) Social Worker State Human Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Zetti Denard ဂ္ Linda Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 5509 Wesley Ave., Baltimore, Maryland 21215 John R. Snowden / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Ceme. 01/11/2005 Owings Mills, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of FacilitThe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Congestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Sreast that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown ģ raner uns ceruicate has been signed I funeral director, page 2 should be deti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Be Completed 1 Yes 2 No 3 Probably Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2X No 1 ☐ Yes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 € ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Droducky en Mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin J. MD 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 0 5 2005

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			1 - For State Registrar	State of Maryla		artment of I		_	giene Reg. No.2 ()	01, 1,1017
	Physici /Medi		1. Decedent's Name (First, Middle, Last	SMITH,				2. Date of De Month	ath Day	3. Time of Death Year 6:45 P M
	Examir		4a. Facility Name (If not institution, give Future Care 5. Social Security Number 6. Se	x 7. Age (In yrs	i. last birthday)	4b. City, Town, Balto	If Under 24 I	Hrs. 8. Date of Birt	4c. County N/A	of Death 9. Birthplace (State or Foreign
	Director		219-05-4544 15 Usual Residence of Decedent 10a. State 10b. County	2M 2□F 89	Yrs.	Months Days	Hours N	fin. (Month, Da 6-10	y, Year) -1915	Md Md
	the Maryla 28e-f shor	rector	Md N/A		Balto	10f. Zip Code			10g. Citizen of V	10d. Inside City Limits 17 Yes 2 No
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)	S O O O		29b. Signature and title of certifier	40		29c. Licens	011	. 1	,	(Month, Day, Year)
6	27		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type, F	St. B	allime	ore MS	2/20)
*	Sta Registr	- 4	31. Date filed (Month, Day, Year) 20	05 Registrar's Signa	ature	refin)				

			1 - For State Registrar	State of Maryland		ment of H		and Menta	l Hygien	611113	41918	
	Physici	an	1. Decedent's Name (First, Middle, Last) ISAAC		CA	J=		Mo			3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	46	. City, Town, or	r Location o			c. County of De		
			THE JOHNS HOPK	INS HOSPITA			none	City				
	Funeral Director		5. Social Security Number 6. Sex 213-49-8339	7. Age (In yrs. la 1 30		If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1974 9. Birthplace (State or Formula Min. February 6 1974 Liberia						
	ס		Usual Residence of Decedent					теы	luary 0		LDella	
	show	ž	10a. State 10b. County		Town or Location						10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	28a-f	recto	MD Montgome:	ry Ta	akoma Pa	YK Of, Zip Code			10g. C	itizen of What C		
	h with	al DI	7520 Maple Avenue			20912				S.A.	•	
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ita	ian: T	BeC	25. Was case referred to medical examiner?				26. Place	of Death (Chec	Yes 2/3(N k on <i>ly</i> on <i>e</i>)	o 1 ☐ Ye	s 2XNo	
<u></u>	hysic this ce al dire	မ	1 □ Yes 2 No			DOA Oth	4 🗀 1401	rsing Home 5[ecify)	
ono	ding P h. After I funera	tlon;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ N		scribe how inju	iry occurred		
Jivisi	l or Attending after death. Director: After In by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				28f. Loc	cation (Street a y or Town, Stat		ural Route Number,	
_	Hospital 4 hours Funeral iely filled	edical Ce	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	sician: To the best of my knowner: Ond measure stated	vledge, death occ on and/or investi	curred at the tim gation, in my o	ne, date and pinion, deat	d place, and due th occurred at th	to the cause(s	s) and manner a	s stated. e to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and little of certifier	and manner stated.	-	29c. License	e number		29d. Da	ate signed (Mon	th, Day, Year)	
	->->		1 finde	MD		RES	-00	0	DECI	EMBER 2	8 2004	
1	16		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Prin	1)				, DUIN ON	21287	
1	('		ERIC WEISS MD PO 31. Date filed (Month, Day, Year)	OBOX 110 TOWI	ER 600	JORTH W	OLFES	STREET	BALTI	MORE,	MARYLAND	
	Sta Registi		.IAN 0 5 2	32. Registrar's Signatu	Di Page	AGE!						

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19b, 20b-c. perFH, INF G839 1/11/05 TT State of Maryland / Department of Health and Mental Hygiege () () L 1- State Registrar Amend item#10c,10e, perFH, G830 er##@50 NDeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Mohammed December 12 1115 Smarton /Medical 4a. Fapility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Ecorge's George's Hospital Center liuce 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 578-68-8183 Director 04-06-1950 Lagos, Nigeria Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ?7 is marked other than "natural", or itams 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 10d. Inside City Limits MD Prince Georges Director Hyattsville Landover Hills 1 XYes 2 No 10e. Street and Number 6602. Webster Street 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. death Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2X No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ lf Yes, Give Y*e*ar or Dates: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private 12th s 1 and 2 should be filed w I Health and Mental Hygier Item 27 Is marked other th Nurse Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Azeez Smarton Awat Atanda 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number of Bural Route Number City of Town, State, Zio Code) 0532 Webster St. Landover HILLS PG, MD, 29784 t of Health a Aishat Smarton/Wife other t permit. Pages 1
Department of He
Important: If Iten
any injury or oth 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 200. Place of Disposition (value of cametery, crematory or other place)

Washington Natl Cementery

01-07-05 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland 4 Donation 5 □ Other (Specify) 21. Signature of Fur-ral Service Licens 22. Name and Address of Facility JB Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Autorios claratic Hyperterine Heart Disease **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physiclan and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I he 9 Unknown 9 Unknown þ signed l I be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2⊟ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. within 24 hours efter death.

To the Funeral Director: A completely tilled in by the ti investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HU055727 Dec enter 15, 2004

State

Registrar

32. Registar's Signature

Maria

3001 Hospital Drive Cheverly

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2005

SALVADOR Sylvete,

31. Date filed (Month, Day, Year)

		•	1- For State of Maryland / Department of Health and M Certificate of Death	ental Hygie	2004	41920
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Dav Year	3. Time of Death
	/Media	al	Lock woob STLLES 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	DECEMBEI	2 30 2004 4c. County of Death	5:30PM
	Examir	er	BOX SECOURS HOSPITAL BALTIMON	ZE.	VIA	
	Funeral Director		117-10-6765 12M 2DF 89 Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Ye	9. Birthp	lace (State or Foreign try) RY/AND
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
	he Mai	ector	MY, N/A PATIMONE	1.2		1 € Yes 2 □ No
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Item Exach at must be cellfied at	Funeral Director	10e. Street and Number 10f. Zip Code 1227	10g.	Citizen of What Cour	itry?
	tems 2	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
936	urs afte	by	1 Never Married 2 Married		Specify: 3	vK
5-0036	72 hor	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin	166	o. Kind of Business/Inc	dustry
2121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+) FOLIMARY MARY		FURNACE	
	al Hygi d other svent, I	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Main	den Sumame)	
Maryland	hould be to discount to marked of matic ever	10	19b. Mailing Address (Street, and Number or Ryral	CP 711	HD 7	Codel
	and 2 sho alth and 127 is m er traum		JUTITITH ADAM? GOS MCKEAN AND	E. BAH	100, 21	217
Baltimore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. It if item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Item Medical Exactions from the rediffical at		1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State cemetery, crematory or other place)	ate 200	Location - City or To	wn, State
İtim	tmer tant		*4 Donation & Other (Specify) 21. Signature of Funeral Service Lices of Service 22. Narrie and Addless & Control of the Service Control	WADATA	AJUNGVIJA	- 11/1/
Ba	permil Depar Impor any ir		Jour A Mari 270 Troday Jan 8	105 5 100	IT, 1117, 1	1229
U			23a. Part Heighth disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or reart failure. List only one cause on each line.	r respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease of Indition resulting in death) AROSTATIC CAN CER Due to (or as a consequence of):			
	Examiner		PRILEMONIA			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. ARTERIO SCLEROFIC CARDIOVAS	coulso	X	سو م
o,	cate be executed bhysician and the burial-transit	Exar	that initiated events resulting in death) Last C. ARCHIER OF CARCOTTC CARCO	CULATR	DI SEH	> <i>E</i>
8760,	icate be executed physician and s the burial-transit	dical	d			
ox 6	leath certific attending p i for use as	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ry
Ω.	The law requires that the death certific to has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1		Month	Day Year
P.0	that the de led by the a detached t	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	e cause of death?
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ecc	a law re has be e 2 sho	Completed		24a. Was an autopsy	24b. Were autor	psy findings available appletion of cause of
Vital F		e Cor	25. Was case referred to medical 28. Place of Death	performed	No 1 ☐ Yes	2 No
of Vi	hyalcian: this certific al director,	To B	examiner? Hospital: Other		e 6 ☐ Other (Specify)
o uc	tter ner		1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?	8d. Describe how in	njury occurred	
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ā	urs afte			City or Town, St		
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	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, L	•
•	(1) North and address of norther with a small of the day	De	comber "	30,2004
	H		Nouth K. Cruzm D D00303 TS 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) ROSITA R. CRUZM-D BON SEC	COURS	HOSPI	TAL
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 2005 22. Registrar's Signature			

			For State Registrar	State of I	Marylar		artment				lental Hy	gien	7 11111	41921
	Physici		1. Decedent's Name (First, Middle JAMES H. SMITH	, Last)							2. Date of De	eath Da	ay Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution UNION MEMORIAL I	-	er)		4b. City,		Location o	of Death	HCC .	40	c. County of Dea	
	Funeral		5. Social Security Number			last birthday)	If Under Months		If Under:	24 Hrs. Min.	8. Date of Bi	rth av Year	Q Bir	tholago (State or Foreign
	Director		218 70 8045 Usual Residence of Decedent	1G-W 201		46 Yrs.					APRIL 2	25,	1958MAR	
	Marylar F show	tor	10a. State 10b. County	N/A		ty, Town or Lo TIMORE	cation							10d. Inside City Limits 1X Yes 2 ☐ No
	with the a or 28s	Funeral Director	10e. Street and Number 3808 WINDSOR MI	I. ROAD			10f. Zip 212]					10g. C	itizen of What C	ountry?
	r death	uneral	11. Marital Status	12. Was Decede Armed Force	s?		Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi	
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	e filed within al Hygiene. I other then " vent, the Med		GED 17. Father's Name (First, Middle,			COOK/I	REPAIF	RMAN	18 Mothe	ar's Name	(First, Middle		PITAL	
Maryland	should be and Mental marked o umatic eve	To Be	JAMES SMITH SR.						MARY	NICK	ENS			
	O1 (G 0) 65		19a. Informant's Name/Relations MARY EVANS (MOTI			1							or Town, State, YLAND 2	
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tra		20a. Method of Disposition 1 Burial 2 XCremation		10	Place of Dispo cemetery, crer	sition (Nam natory or ot	ne of ther place	9)	C	ate	20c. L	ocation - City or	Town, State
altin	permit. Pages Department of Importent: If i any injury or once.		* 4 Deponation 5 ☐ Other (S)	1 11	GRI	EEN MOU	JNT CF . Name and	REMAT d Addres	S of Facility					, MARYLAND JNERAL HOME
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ŀ	Examiner			Due to (or b.	as f a conseq	ruence of):								
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8760,	cate be executed physician and the burial-transit	al Exa	resulting in death) Last	Due to (or	as a co seq	(uence of):	1	15.5						
9	death certificate be executed e attending physician and of or use as the burial-transit	Medic	IF FEMALE:	d		×ø.				-				
.O. Box	that the death certific ed by the attending p detached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Feta at time of d	ıldeath 3□	Ectopic pre Other (spe		-				23d. Date of de Month	livery Day Year
Q	quires that the signed by	þ	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying ca	use give	n in Part I.			obacco Yes 2	_	o the cause of death?
Division of Vital Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed				-					24a Was auto perfo		prior to death?	utopsy findings available completion of cause of
Vita	ysicien: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	stient 2	ER/Outpatien	t 3□ DO/	A Othe			(Check only o	опе)		
n of	Attending Physicien: If death. ector: After this certification by the funeral director.	lon; To	27. Mannet of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, I		28b. Time of Injury	28	Bc. Injury Work	at ?	2	28d. Describe		6 □Other (Spe iry occurred	city)
Divisio	l or Attend after death Director: /	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	ot be 28e. Place of	Injury - At ho etc. <i>(Specif</i>	ome, farm, str (y)	M eet, factory,		′es 2 □ N		28f. Location (. City or To	Street ai wn, State	nd Number or Ri e)	ural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be Examiner: On the basis and manner	of examina	owledge, death	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s date an) and manner as d place, and due	s stated. a to the cause(s)
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F	1		30. Name and address of person	who completed cause o	f death (Iten	п 23а) (Туре,	Print)	1)(10 1	ر در	/	1	2-30-	07
-1	Sta	te	31. Date filed (Month, Day, Year)	INTON II	- MD strar's Signa	ature	201	E B	Univ	versi	ty Par	KW	ay 21=	218
	Registr		JAN 0	5 2005	ALLES .	Jo P								

	li	For State Registrar	State of N	Maryland / Dep <i>Ce</i>	ertificate of I			giene Reg. No. 200	4 4192
Physic /Medi		Decedent's Name (First, Middle, Last) SCROGGINS						3/ 2004	e:STAM
Examir		4a. Facility Name (If not institution, give sold) OLD DEATON UNIVERSI	TY SPEC	IALTY HOSP.	BALTIMOR	r Location of Death E If Under 24 Hrs.		4c. County of De	
Funeral Director		5. Social Security Number 214 58 9112 Usual Residence of Decedent	M 2 💢 F	Age (In yrs. last birthday 52 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da APRIL 3	v. Year)	Birthplace (State or Foreign Country) RYLAND
e Maryland le-f show	ctor	10a. State 10b. County MD N/7		10c. City, Town or L BALTIMORE					10d. Inside City Limits 1X Yes 2 □ No
th with th	al Director	10e. Street and Number 1303 N. EDEN STREET	1		10f. Zip Code 21213			10g. Citizen of What (U.S.A.	Country?
be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or items 23e or 28e-f show event, the Medical Examinar must be routiled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Deceder Armed Forces 1 Yes 2 I If Yes, Give Year or Dates	s? X No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Black, WI	nerican Indian, hite, etc.
within 72 hou ene. then "nature he Medical E	npleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		r 5+) (Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of world		16b. Kind of Busines	ss/industry
ould be filed w Mental Hygier arked other ti atic event, th	Be	10th 17. Father's Name (First, Middle, Last) JAMES WESTER		NURSI	NG ASSIST	-	ne (First, Middle,	PRIVATE NU Maiden Sumame)	JRSING
nent of Health and ent: If item 27 is m ury or other treum	-	19a. Informant's Name/Relationship (Ty, NINA SCROGGINS (DAI 20a. Method of Disposition 1 Dourial 2 □ Cremation 3 □ R 2 Donation 5 □ Other (Specify) 2 Signature of Funeral Service License	GHTER)	20b. Place of Disp cemetery, cre GARRISON	N. EDEN institution (Name of ormatory or other place) FOREST C	STREET BA STREET BA (e) JANUA EMETERY	ral Route Number ALTIMORE Data RY 6, 2	MARYLAND OUS-Location - City of BALTIMORE, SCRUGGS F	21213 or Town, State
Cate be executed Medical Medical Examiner the burial-transit	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	ed the dath. Do not en line.	nter the mode of dyin	g, such as cardiac			Approximate Interval Between Onset and Death II-45-04
The raw requires that the beart certification in the bas been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ Mo 9 □ Unknown		2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	lelivery Day Y <i>e</i> ar
n signed t	by	Part II. Other significant conditions con Deep bein threm he	13 . AI	Ds, Chre					to the cause of death? Probably 4 Unknown
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Physicien: r this certifica ral director, p	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpat		ont 3 DOA Other	26. Place of Dear	ome 5□Resid	ne) dence 6 □ Other (Sp now injury occurred	pecify)
after death. Director: After thi I in by the funeral (ertification;	1 Matural 5 Pending 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28e. Place of h	njury - At home, farm, s		<br Yes 2□No	28f. Location (S City or Tox	Street and Number or i n, State)	Rural Route Number,
Hospite 4 hours Funeral ely fillec	ledical C	29a. Certifier 1 Certifying Physical Check only one)	icien: To the bes er: On the basis and manner s	st of my knowledge, dea of examination and/or in stated.	th occurred at the time	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License	3ULIAH		29d. Date signed (Mon	
3/1/	te	30. Name and address of person who co In LSA i University 31. Date filed (Month, Day, Year) JAN 0 5 200	ry spec	death (Item 23a) (Type filly hespla- trar's Signature		tu charle	d St Bo	alhmare N	10 21236

54166 acs

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 22, 2004 **Physician** James Smith 9:13 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year Feb 23, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1XM 2□F 579-38-3756 73 Director Usual Residence of Decedent death with the Maryland 7 is marked other than "naturel", or itema 23a or 28e-f show traumatic avent, its Medical Examinational be rediffed at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Riggs Road 20783 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No U. If Yes, Give Year or Dates: unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel', or Item any injury or other traumatic avent, the Medical Examinat once. unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖾 Other (Specify) in state 21. Sunature of Euneral Service Licensee Ronal L. S. Wa State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Mrector Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Ishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) o ticermo /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner signed by the attending physician and I be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequen of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ZUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death

1 Natural
2 Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 - Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 046998 tun 7cu D 3415 Hammton ST Hyattoville Mp 20782
Registrar's signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN 0 5 2005

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of M	laryland	d / Depa		t of H	ealth a			_	04	41924
	Physici /Medic		1. Decedent's Name (First, Middle, La Shirley A. Spel							4	2. Date of Dea Month	th Day	Year	3. Time of Death 1628 M
	Examir		4a. Facility Name (If not institution, git	HEALTH	PARE		4b. City,	Town or	Location of	of Death	E	4c. Count	y of Death	
	Funeral Director		218-46-6345	Sex 7. A 1 □ M 2 ▼ F	ge (In yrs. la 58	ast birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day Mar 15,	1946	9. Birth Cou V1	place (State or Foreign ntry) rginia
	Aaryland show	or	Usual Residence of Decedent 10a. State 10b. County MD		10c. City,	, Town or Lo	cation Baltin	nore						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-	Direct	10e. Street and Number				10f. Zip				1	0g. Citizen of	What Cou	
	leath w	erai	3932 Rokeby Road	12. Was Decedent	Ever in U.S	13 \	Was Ooced	ent of His	212		ocity Vos or No	14 Pa	USA	oon Indian
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Exama withing the motified at	by Funeral Director	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Tes 2 Tes If Yes, Give Year or Dates:	?	1	f Yes, speci		Specify:	, Puerto	ecify Yes or No- Rican, etc.)		ick, White,	
Maryland 21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Şegondary (0-12)		5+)	(Giva	dent's Usual kind of work DO NOT use	k dona d	uring most	of worki	ng	16b. Kind of E	Business/In	dustry
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	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship (Clifton Speller/								A Route Number Baltim			207
altimore,	8 5 = 0		20a. Method of Disposition 1 Burial 2 Cremation 3 Content Special Spe	Removal from State by in state	cei	ace of Dispo metery, cren	sition (Nam	e of				20c. Location		
Balt	permit. Page Department of Important: If any injury or once.		21. Ignature of Funeral Service Lice	Worde, Di	egtor	Dè	TLTIMO	re,	MD 4	2120			ore S	Street
	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each I	d the death. ine.	Do not ente	er the mode	of dying	, such as c	cardiac o	r respiratory arre	est,	4	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							,	
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8760,	ate be executed hysician and the burial-transit	lical Exa	resulting in death) Last	Due to (or as	a conseque	ence of):								
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	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		2/2		Other			(Check only one			A
n of	iding Phy th. : After this funeral d	on: To	27. Manner of Death Natural 5 ☐ Pending	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ıry 2	R/Outpatient 28b. Time of Injury		c. Injury	4 L Nurs		ne 5 Resider 8d. Describe ho)
Division	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Inj			М	1 🗆 Y	es 2□N		8f. Location (Str	eet and Numb	er or Rura	l Route Number,
5	spital or nours aft ineral Dir / filled in		29a. Certifier Certifying Ph	ysicien: To the best	of my knowl	ledge, death	occurred at	t the time	, date and	place, a	City or Town,	use(s) and ma	inner as st	ated.
	thin 24 I	Medical	(Check only one) 2 Medicel Exer	niner: On the basis o and manner st	t examinatio	on and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time, da	te and place,	and due to	the cause(s)
	T will		Sura Espi	M	0		-			64		CCVVL		
			30. Name and address of person who Susan IEsporit		leath (Item 2	(Type, F	Print)	- B	altin	205	e Mar	ylan	el	3,2004
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 20(32. Registr	ar's Signatur	Aps.	منا					,		

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Month Yeer 7:48 P SCOTT, SR. EWELL LAKE December 19, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner Salisbury Wicomico Coastal Hospice At The Lake If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 □ F Director 83 214-18-4954 May 14, 1921 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Westover Director Maryland Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ 7192 Old Westover Road 21871 U.S.A. or Items 23a Funerai 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No. World
Year or Dates: War II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status of fled within 72 hours after did Hygiene. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Farmer permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important: If item 27 is marked other then 17 in your or other traumatic event. If a QRGs. Poultry 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marvin Wesley Scott Helen Sterling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7192 Old Westover Road- Westover, MD Mary Ellen Scott (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Sunnyridge Memorial Park 12/22/04 Crisfield, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury Tungal Sepice 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw, Jr 306 W. Main St.- Crisfield, MD 23a. Part1. Enter the disease, or complications that to sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition Priysician MAIN Due to (or a s consequence of): cencer resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulsease or injury that initiated events Due to (or as a consequence of) Examiner death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown for Month Day Year 5 Other (specify) detached 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 3 Probably 4 □Unknown 2 🗆 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No 2 No 1 ☐ Yes 1 Yes or Attending Physician: ector. Be 25. Was case referred to medical 26. Place of Death (Check only one, Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 PNatural 5 Pending 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Onfile BOX 70 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 05 2005

		•	For State Registrar	State of	Maryland		artment of I rtificate of				giene Reg. No:	2 H H h	41926
	Physici	an	1. Decedent's Name (First, Middle, La	ist)						2. Date of De. Decembe		9, 2004	3. Time of Death 4:40 P M
	/Medic	al	TAVON TA! 4a. Facility Name (If not institution, given		ahar)		4b. City, Town,	or Location o				County of Deat	
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	Funeral		5. Social Security Number 6. S	Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under	Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State or Foreign untry)
	Director		217-13-9672 Usual Residence of Decedent	1XM 2□F	1	8 Yrs.				JULY 26	5 198	36 MAI	RYLAND
	/land		10a. State 10b. County		10c. City	, Town or Lo	ocation				-		10d. Inside City Limits
	a-fsh	ctor	MARYLAND N/A			BALT	IMORE CI	ľΥ					1 X Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code					izen of What Co	ountry?
	eath v		7 0 9 N LONGWOOD		dent Ever in U.S	S. 13.	212 Was Decedent of	Hispanic Orio	gin? (Spec	cify Yes or No		S.A.	nican Indian,
920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel" or Items 23e or 28e-f show event, I're Medical Exarting must be multiped at	by Funeral	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 [X]No e		If Yes, specify Cub 1 ☐ Yes 2 💢 No	an, Mexican	i, Puerto P	Rican, etc.)		Black, Whit	
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121	within 72 iene. r then "nei	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)		<i>DO NOT</i> use <i>retire</i> DENT	od)			,	N/A	
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	s 1 and 2 should f Heelth and Mer Item 27 Is marke other treumatic		Cecilia Sellman/	Mother	20h Pi		9 N Longs	wood S		Baltimo		Md., 2.	
סכ	Pages 1 nent of H nnt: If lite iry or ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 [State C6	metery, cre	matory or other pla		1-04-				, MARYLAND
Baltimore,			*4 □ Donation 5 □ Other (Special Section 21. Signature of □ Teral Section 21.	90	MT	2.	CEMETERY 2. Name and Addr	ess of Facilit	tv				
ñ	permit. Depertr Importe any Inju		· ////	Ixour	v	W	ILLIAM C 206 W NO	RTH AV	ENUE	MONTTY	FUNI	ERAL HO	ME P.A.
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8760,	cate be executed physician and the burial-transit	ai E	L. Control of the Con	Due to (or as a consequ	ierice orj.							
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Box	The taw requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregna irth 2 Petal ant at time of de own	death 3	□Ectopic pregnand □ Other (specify) _	су				23d. Date of del Month	ivery Day Year
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ords	w require been sig should b	ed b								10	Yes 2	X No 3□Pi	obabiy 4 Unknown
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of	Phys this al di	. To	1 XYes 2 No 27. Manner of Death		-	ER/Outpatie	IL SEL DON	4 🗆 140		8d. Describe		6 □Other (Spe ry occurred	cify)
on	Attending ir death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation		of Injury th, Day Year)	Injury Found 4:0	W	ork?]Yes 2 1 0	No	subject	tw	as sho	T
Division	Attended of dear	Certification;	3 Suicide 6 Could not determined	be 28e. Place		me, farm, st	reet, factory, office		2	8f Location /	Street an	nd Number or Ri	ural Route Number,
Ö	Itel or irs afte rel Dii led in					5	treet			treet	Balt	imore	MP
	Hosp 24 hou Fune stely fil	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☑ Medical Exa	hysicien: To the miner: On the ba and manr	asis of examinat	wledge, deat tion and/or in	h occurred at the to vestigation, in my	ime, date an opinion, dea	nd place, a ath occurre	nd due to the ad at the time,	date and) and manner as d place, and due	s stated. e to the cause(s)
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Me	29b. Signature and title of certifier				29c. Licer	se number			29d. Da	te signed (Mont	h, Day, Year)
) ,			I him his	mid				OCME			Dec	ember 3	0, 2004
ĺ	100		30. Name and address of person who	m.D			111 Penn	Stree	et BA	ltimore	e, M	Aryland	21201
	Sta Registi		31. Date filed (Month, Day, Year)	5 2005 b	egistylr's Signa	ture	from						

		1- State of Maryland / Depart Registrar Certii	tment of H		ygiene Reg. No. 200 L	41927
Physicia		1. Decedent's Name (First, Middle, Last) Hazeline Thomas		2. Date of I Month DECEW	Day Yeer	
/Medic Examine			V 111	Location of Death	4c. County of De	1
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of E (Month, I Apr 2)	Birth 9. Bi	rthplace (State or Foreign country) unk
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	tion	-		10d. Inside City Limits
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altimore, mit. Pages 1 ar partment of Hea portant: if item y injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) in state	ion (Name of tory or other place	p) Date	20c. Location - City o	
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Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter to	the mode of dying	g, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
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Division of Vital Records, or Attending Physician: The law requires tatler death. Director: After this certificate has been signe in by the tuneral director, page 2 should be e	Completed			24a. Wa aut per	opsy prior to death?	utopsy findings available completion of cause of
f Vital Rec nysician: The law nis certificate has I	Be	25. Was case referred to medical examiner? 1 Ses 2 No Hospital: 1 Inpatient 2 Fr/Outpatient	3 DOA Othe	26. Place of Death (Check only	one)	
Division of Vita or Atlanding Physician: after death. Director: Atter this certification by the tuneral director.	atlon; To	27. Manner of Death Tatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury Work	4 Nursing Home 5 Ne	how injury occurred	непу)
Division of to the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	t, factory, office		(Street and Number or Rown, State)	ural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in I	edical	29a. Certifier (Check only one) 1 ✓ Certifying Physicien: To the best of my knowledge, death or one) 1 ✓ Certifying Physicien: To the best of my knowledge, death or one) 2 ☐ Medicel Exeminer: On the basis of examination and/or investant manner stated.				
To the within To the Comp	Σ	29b. Signature and title of certifier	29c. License	04740	29d. Date signed (Mon	
			aven B	Ivd, Baltim	ore, MD	21239
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	A.S		•	
DHMH 17 Rev 1/20	01	ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene 001 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 16, 2004 Physician December 2:00 PMM Richard H. Thiem /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City 4638 Doncaster Drive If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number (rs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec 22, 1931 6. Sex 7. Age (Ir **Funeral** 1 X M 2 □ F 218-28-5080 Director Usuaf Residence of Decedent 10d. Inside City Limits 10a State 10c City Town or Location 10b County 1 show other traumatic event, the Medical Exeminer must be putilised at 1 ☐ Yes 2 🔽 No Director Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4638 Doncaster Drive 21043 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Bfack, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Efementary/Secondary (0-12) engineer mechanical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Department of Health and Menial Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Henry Joseph Thiem Mae Nora Gamache 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary A. Thiem/spouse 4638 Doncaster Drive Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Ronald S. Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 11/1 well 23a. Part n Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. nterval Retween Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** years NOSIJ /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the attending pt IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certiticate has birector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 TYAS or Attending Physician: 25. Was case referred to medical examiner? tuneral director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home ome 5 Residence 6 Other (Specify)
28d. escribe how injury occurred P 3□ DOA this 28a. Date of fnjury (Month, Day Year) 27. Manner of Dear 28b. Time of 28c. Injury at Work? Certification: After 5 Pending A hours after dea.

-rel Director: Atr 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funerel Directory tilled in by the 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 20, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MU Annapols 31. Date filed (Month, Day, Year) 32. Registrar's Signature State donates Registrar JAN 05 2005 PREURI

DHMH 17 Rev 1/2001

				State of Maryla				-			
			1 - For State Registrar	, , , , , , , , , , , , , , , , , , , ,		rtificate of L			eg. No. 2004	41	929
	Dhomini		1. Decedent's Name (First, Middle, Last)			CO TI	- 0	2. Date of Dea Month	th Day Year		of Death
	Physici /Medio		ROBERT		000	5BSTE		DECEMBE	R 22 200		12 PM
	Examir	ner	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Deat		_
			NORTH WEST H		s. last birthday)		CCSTOW/ If Under 24 Hrs.	8. Date of Birth	BALTI		
Н	Funeral Director		5. Social Security Number 6. Sex 213-16-5468	M 2□F 83	Yrs.	Months Days	Hours Min.	Sept 13	Year) 1921	untry)	te or Foreign UNK
	P .		Usuel Residence of Decedent	10- 6	City, Town or Lo			·		404 1	City Limite
	Aaryla f show	ō	10a. State 10b. County MD Baltimo			esville					e City Limits ′es 2 ∑ No
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if health and Mental Hygiene. If the sith and Mental Hygiene. If the marked other then "natural", or items 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?	
,	23e o	ralD	7 Sudbrook Lane				21208		USA		
	er de	nue		2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- c Rican, etc.)	14. Race - Ame Black, Whit		le .
36	irs afte	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ፫ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🏋 No	Specify:		Specify: wh	ite	
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation	king	16b. Kind of Business/	Industry	unk
21	ithin 16.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	kind of work done of DO NOT use retired		any .			
S	filed withi Hygiene. other then			nk		maintena		o /Fina baidala	Maidan Cumamal		
=	ould be fi Mental H arked oti atic ever	o Be	17. Father's Name (First, Middle, Last)			unk	18. Mothers Nam	10 (FIFST, MIGGIO,	Maiden Sumame)		unk
ary	2 should and Men is marke eumatic	^L	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailie	ng Address (Street a	and Number or Ru	ral Route Numbe	r, City or Town, State, 2	Zip Code)	
	1 and 2 Health a em 27 iu		Northwest Hospita	L	5401	01d Cour	t Road R	andal1st	own, MD 2	1133	
ore,	of He		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place		Date	20c. Location - City or	Town, State)
imo	Pages ment of ent: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	insstate							
Baltimore,	permit. Pages 1 and Depertment of Health Importent: if Item 27 any injury or other tr <u>QDC®</u> .		21. Signature of Funeral Service License W	ade biracto					Baltimore	Stree	t
			23a. Pank. Enter the disease, or complic	cations that caused the dea		altimore. ter the mode of dvine			rest.	Approxir	mate
	Duminian		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Onset a	Between nd Death
	hysician /Medical		disease or condition resulting in death)	SASTRO Due to (or as a conse		STIDAC	DLCC				
	Examiner		Sequentially list conditions b								
-	be is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	учивите от).						
	xecute and Il-tran	xam	that initiated events resulting in death) Last	Due to (or as a conse	equence of):						
760,	eath certificate be executed ettending physicien and for use as the burial-transit	caiE			, , , , , , , , , , , , , , , , , , , ,						
687	ificate g phy: as the			-							
Вох	endin endin	M/U	230. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		⊒Ectopic pregnancy			23d. Date of de	-	
Э. В	The law requires that the death certificate be executed tie hies been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physiclan/Med	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day	Year
P.0	hat thi d by t detach	Phy	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not re	eulting in the u	inderhina cause and	en in Part I	23a Did to	bacco use contribute to	the cause	of death?
Records,	signed d be de	d by		LURE	Journal III (III)	maonymy baass gree	on my with		es 2⊡No 3⊡Pi		Onknown
cor	w requir been s should	ete						24a. Was a	an 24b. Were at	utopsy findir	ngs available
Re	sician: The law certificate hes b irector, page 2 s	Completed						autop perfor	sy prior to death?	completion : 2 \(\text{No} \)	
Vital	an:] rtifical tor, p	a	25. Was case referred to medical				26. Place of Dea	th (Check only or		20110	
of V	Physician: this certificatal director, I	ToB	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing H	ome 5 Resid	ence 6 Other (Spe	city)	
0	ding Pt I. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	k?	28d. Describe h	ow injury occurred		
isio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	One Diese of Leives As	hama (a.e		Yes 2□No	29f Location /S	treet and Number or Ri	usal Pouta I	Number
Division	i or Al after o Direc	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, st cify)	reet, factory, office		City or Tow	n, State)	Irai moute n	rainber,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate in completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	ician: To the best of my ki	nowledge, deat	h occurred at the tim	ne, date and place	, and due to the o	ause(s) and manner as	stated.	
	he Ho in 24 l he Fu pletely	Medicai	(Check only 2 Medical Examir one)	er: On the basis of examinand manner stated.	nation and/or in	ivestigation, in my of	pinion, death occu	rred at the time, o	date and place, and due	to the caus	30(S)
	To t	Σ	29b. Signature and title of certific	0		29c. License			29d. Date signed (Mont		
,			1	X	MP		1722		DECEMBER		2004
			30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type,	Print)	ANIONIE	T((u)a)	0 21122		
	Sta	ate	JEONARP RICHARDSO, 31. Date filed (Month, Day, Year)	32 Registrar's Sig	nature	NOTO F	HOPFICES	1000	P 21133		
	Regist		JAN 0 5 200	Blocker A	y Agos	all .					

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			1 - State Registrer	te of Maryland	d / Depar <i>Cert</i> i	tment of Ho	ealth and Death		giene	2004	41930
)	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Charle Thomas 4a. Fecility Name (If not institution, give street as	Willam nd number)		4b. City, Town, or	Location of Deat	2. Date of De Month	Day 31	Year D 4	3. Time of Death
y	Funeral Director		University w Marylos. Social Security Number 0 6. Sex 213-64-6865	7. Ago (In yrs. 12	Ctr.	-	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th	9. Birth	place (State or Foreign ntry)
	death with the Maryland ms 23a or 28a-f show rmal be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County Md . NA	10c. City	Town or Loca						10d. Inside City Limits 1 X Yes 2 □ No
	ath with the 23a or 28	ral Director	10e. Street and Number 2105 E. Oliver Stree	et.		10f. Zip Code 212	213			on of What Cou USA	ntry?
036	ours after rai', or ite Everrine	by Funeral	1 Never Married 2 Married 1 ☐	Decedent Ever in U.S ed Forces? Yes 2 Moo es, Give r or Dates:	If Y	as Decedent of His es, specify Cuban Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		Black, White,	
9500-61212	d within 72 giene. ir than "nai I're Medic	Completed	15. Decedent's Education (Specify only highest grade complete the complete state of the	ege (1-4or 5+)	(Give kil lite. DC	nt's Usual Occupa nd of work done do NOT use retired)	uring most of wo	rking		of Business/In	erve Bank
ıryıand	d 2 should be filed th and Mental Hygi ?? is marked other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Charlie 19a. Informant's Name/Relationship (Type, Prin		Willian		Lilli	-	Maiden S	umame) Sutto	on
lore, ma	1 and 2 Health a Sm 27 is		Lillie M. Williams 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal	Mother 20b. Pla	2105 ace of Disposit metery, crema	E. Olive ion (Name of tory or other place	r St.,	Baltimor Date	e, Mc 20c. Loca	2121 ation - City or To	3 own, State
baltimore,	permit. Pages Department of the Important: If ithe any injury or of once.		21. Signature of Funeral Service Licensee	Jane_	Ma	Name and Address	East	Balt 1101	imore E. N	dallstov e, Md. North Av	21202
	Physician /Medical Examiner		23a. Part1. Enter the disease, or emplications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. on each line. LVQVQL ue to (or as a conseque	Eden			or respiratory ar			Approximate Interval Between Onset and Death
9/00,	ite be executed sysicien and ne burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a conseque							
O. Box 6	death certifi. e attending I d for use as	Physiclan/Med	in the past 12 months?	s, outcome of pregnan Live birth 2 Fetal of Pregnant at time of dea Unknown	death 3⊟Ed	ctopic pregnancy other (specify)			23	d. Date of delive	ery Day Year
rds, F	The law requires that the site has been signed by the bage 2 should be detache	ρ	Part II. Other significant conditions contributing	to death but not result	ting in the unde	arlying cause giver	n in Part I.		obacco use		ne cause of death?
vital Records,		e Completed	25. Was case referred to medical						2 U No	death?	psy findings available apletion of cause of 2D No
5	ng Phy liter this	To B	examiner? 1 Yes 2 No Hospital: 27. Manger of eath 1 Natural 5 Pending	-	P/Outpatient 28b. Time of Injury	3 DOA Other 28c. Injury a Work?	4 □ Nursing H	ome 5 Resident Reside	ence 6[()
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At hom building, etc. (Specify)	nø, farm, street		es 2 No	28f. Location (S City or Tow	itreet and I m, State)	Vumber or Rura	l Route Number,
	the Hospi ain 24 hou the Funer apletely fill	edical		o the best of my know the basis of examinatio manner stated.	ledge, death or on and/or inves	tigation, in my opii	nion, death occu	rred at the time, o	date and pl	ace, and due to	the cause(s)
B	To To Con	Σ		ID.			0435KIS	5949	12/31	signed (Month,	
1	01	•	30. Name and address of person who completed Sabring Kratz University of 31. Date filed (Month, Day, exeat) A : 31. Date filed (Month, Day, exeat)	f Maryland N	Med Ctr	225. Gr	reene St	reet Bal	tî mer	re, MD	21201
	Sta Registr	_	31. Date filed (Month, Day, AR) 0 5 200	22. Registrar's Signatu	72. W						

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Marshall Willett 12 28 2004 Nathaniel 0924 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JHH Bayview Hospital Baltimore NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 X M 2 □ F 215-52-4979 55 Yrs Director 6-19-49 Md Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show other treumatic event, the Medical Exeminer must be notified at Y∏Yes 2 ☐ No Director Baltimore NA Md. 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number filed within 72 hours after death with USA 21206 4611 Hazelwood Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced "natural" Be Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then 'any injury or other treumatic event, the Magnite. Elementary/Secondary (0-12) College (1-4or 5+) Co Ordinator Beth. Steel grade 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ethel ဂ Η. Willett Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4611 Hazelwood Ave., Baltimore, Md. Wife Cynthia Willett 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cem. 1 - 3 - 05Baltimore, Md. 21. Signature of Funeral Service Licens ie 22 Name and Address of Facility Baltimore, Md. 21202 Semond MANNE March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arrhythmia Immediate /Medical Due to (or as a consequence of) Examiner Pulmana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit OPD and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed Deed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 2 ☑ No 1 ☐ Yes 2 ☐ No 1 Yes lel or Attending Physiclan: Ti s after death. sl Director: Atter this certificate ed in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel c within 24 hours aft To the Funerel Di l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30 42232 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Biltimore, 2112 Dundalk 32. Regisar's Signature 31. Date filed (Month, Day, Year) State 5 2005 Registrar

Rubin White 04-8074 DOS

			1 - For State Registrar	State of Mai		artment of He rtificate of D			iene 0 0 l	4 41932
	Physici /Medic		1. Decedent's Name (First, Middle, La Rubin White	st)				2. Date of Deat Month Decembe		3. Time of Death 0813 a M
	Examir Funeral		4a. Facility Name (If not institution, giv 3003 Cherryland 5. Social Security Number 6. S	Road apt.	(In yrs. last birthday)	4b. City, Town, or Baltim If Under 1 Year Months Days		8. Date of Birth (Month, Day,	4c. County of	Birthplace (State or Foreign Country)
Jack	Director		251-52-2307 Usual Residence of Decedent 10a. State 10b. County		59 Yrs. 10c. City, Town or Lo			Jan 31,	, 1935 Sc	outh Carolina 10d. Inside City Limits
Mad Man	28a-1 st	Director	MD 10e. Street and Number		Balt	imore		10	0g. Citizen of Wh	1 Yes 2 □ No
ath with	23a or	ral Dir	3003 Cherryland			2122			USA	
5-0036	omening to the control of the contro	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc. black
121	iene. Than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) unk	ducation ade completed) College (1-4or 5+) unk	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)		unk	16b. Kind of Busir	ness/Industry unk
and 2	svent,	Be	17. Father's Name (First, Middle, Last,)		unk	18. Mother's Name	(First, Middle, M	Maiden Sumame)	unk
, Maryla	and is m	J.	19a. Informant's Name/Relationship (Katie Scriber/ni	**		ng Address (Street ar			, City or Town, Sta	ate, Zip Code) unk
ore 1	Department of He important: If iter any injury or oth once.		20a. Method of Disposition 1	y) in state	-	matory or other place)		20c. Location - Ci	
Bal	Depar Impor		21. Signal is of Euneral Sen ce Licer Ronal S	11000	Dà	2. Name and Address tate Anato altimore,	MD 21201	L		re Street
	nysician /Medical xaminer	er	23a. Part 1. Enter the disease/or comshoot, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. A HOO Or as a b.	SCLEVOTO consequence of):					Approximate Interval Between Onset and Death
68760,	physician and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of);				-	
Records, P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	,
ords, P	been signed b	by	Part II. Other significant conditions of			nderlying cause giver	n in Part I.			ute to the cause of death?
		Completed						24a. Was ar autopsy perform 1 Yes 2	prio ned? dea No 1	re autopsy findings available or to completion of cause of th? Yes 2 No
of Vita	this certifical	To Be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient	2 ER/Outpatien	nt 3 DOA Other	4 Nursing non			(Specifyat scene
	in eli	ertification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation		28b. Time of Injury	Work?	at 2 es 2 □No	8d. Describe ho	w injury occurred	
Division alor Attendance	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certific	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office	2	8f. Location (Str City or Town	reet and Number (, State)	or Rural Route Number,
Hospii	24 hours e Funera letely fille	edicai (nysician: To the best of niner: On the basis of e and manner state	xamination and/or in					
Ę	withir To th	Me	29b. Signature and title of certifier	llaam	S	29c. License OCME		29	Decembe	Month, Day, Year) er 16, 2004
			30. Name and address of person who	LAwno		111 Penn	Street E	Baltimor	e MD 212	201
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 206	32. Registrar	s Signature	W.				

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death December **Physician** 30, 2004 8:30 A M Mary Lee Watterson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 X F West Virginia Director 1-27-1929 577-34-0759 death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Modical Examiner must be notified at 1 Yes 2 No Annapolis Anne Arundel Director Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 USA 2500 Eastern Point Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should ba filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itel 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Weese Jack McAleer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Eatern Point Ct., Annapolis, MD 21401 Jack M. Watterson/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 1-4-05 Clinton, MD Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense 22. Name and Address of Facility George P. Kalas Funeral Home Why Ville 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Josocomial Paramonia -**Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) signad by the a 9∏ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diente Renn Failure 1 Yes 2 No 3 Probably 4 Unknown OPO 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy performed Cancer 2 110 or Attending Physician: 25. Was case reverred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔟 2 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation ours after death.

neral Diractor: Affilled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature s 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I center, Annapolismo 21404 MO Anne Ara 1-00m20 שנאטם 31. Date filed (Month, Day, Year)
JAN 0 5 Registrar's Signature 32 State 2005 Registrar

			Please Type or Print in Black I State of Maryland / De	partment of Health and M	_	
			- nagistiai	ertificate of Death		Reg. No.
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of De Month	Day Year
	/Medic	al	Brenda L. Simmons Yarosh 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Dec.	19 2004 10:25a M
	Examin	er	Harford Memorial Hospital	Havre de Grace		Harford
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Bir (Month, Da 09/25	
	Director		220-62-3569 1 M 2 XF 53 Yrs.	Moralis Days Floars Minn	09/25/	/1951 Maryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryl fed a	ŏ	MD Harford Havre	de Grace		1 XYes 2 □ No
	hours after death with the Maryland turat', or frame 23a or 28a-f show al Examinar must be notified at	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?
	th with		223 Seneca Avenue	21078		USA
	ams ams	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No Rican, etc.)	p- 14. Race - American Indian, Black, White, etc.
36	s afte	y F.	1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: White
8	turat		15 Decedent's Education 16a, De	cedent's Usual Occupation		16b. Kind of Business/Industry
215	hin 72 9. an "na Medi	plet	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired)	ing	
Maryland 21215-0036	be filed within 72 hours after death with the Marylar lat Hygiene. d other then "natural", or items 23a or 28a-1 show of other then "natural", or items 23a or 20a's shown, the Medical Examinat roust be notified at	Completed	12th Nu	rsing Assistant	- /Ci A & disdulla	Nursing Home
and		Be	17. Father's Name (First, Middle, Last)			, Maiden Surname)
7	should be and Mental s marked o umatic eve	ပ	Walter FreeIs 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Nellie M		er, City or Town, State, Zip Code)
Ma	2 60 50 5			Lafayette St., Hav	re de C	Grace, MD 21078
ře,	is 1 and 2 of Health itam 27 i		20a. Method of Disposition 20b. Place of Dis		Date	20c. Location - City or Town, State
Ē	Pages nent of ant: if it		1 ☐ Burial 2 (Acremation 3 ☐ Hermoval from State R.A. Fe	rris & Co. 12/23		West Chester, PA
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Nitchell-Smith Fune 123 S. Washington,	ral Hon	ne, P.A.
	205 20		25a Paol . Enter the disease, or complications that caused the death. Do not	23 S. Washington,	Havre	de Grace, MD 21078
ı			shock, or heart failure. List only one cause on each line.) _	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	belic encept	naliti	2
ı	Examiner		20	2btic Shock		
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	0	
	ecuted ind transit	amin	that initiated events c.	Of BBDom	mal	0715m
60,	be execian a	E	resulting in death) Last Due to (or as a consequence of):) ehydration		
68760,	physicate to the the the the the the the the the the	dle	d	JE VIG WIGHTOM		
Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medical		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the ed by detact	/ Ph	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	tobacco use contribute to the cause of death?
ds	w requires that been signed to should be det	d by	8 le trolyte imbalance		1 🗆	Yes 2 No 3 Probably 4 ⊕briknown
Vital Records,	s beer	Completed			24a. Was	
Re	The la	E O			perfo	ormed?death?
ital	ian: artifica ctor. p	Bec	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only	one)
of <	Physician: this certificant	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpa			idence 6 Other (Specify) how injury occurred
Ľ.	ling P	on:	27. Manner of Đeath 1 ☑ Matural 5 ☐ Pending (Month, Day Year) 28b. Tim (Month, Day Year)		28d. Describe	now injury occurred
Division	Attanding r death. actor: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury, - At home, farm,			Street and Number or Rural Route Number,
Ο̈́	ospital or Attandi hours after death. unaral Diractor: A ly filled in by the fu	erti	4 Homicide determined building, etc. (Specify)		City or To	wn, a(ale)
	To the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Diractor: After this certificate has been properly filled in by the funeral director, page 2	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the red at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the first of th	R	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)
)	11) VIO	Daoal	5	19/31/24

State Registrar DHMH 17 Rev 1/2001 EMEMO CHANDRO.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 0 5 2005

5?

NALR 32. Registrar's Signature

601. S- Union are

Handojace MOSIO78

			1- State of Maryland / Registrar	Depa		Health a		ental Hygi	-	+ 41935	
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death	
	Physicia		MARGARET ANNA ZOLL				1	DEC.	31 2004	9:15a м	
1	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location o	f Death		4c. County of De	path	
			15043 PRICEVILLE RD		SPAR	KS			BALTIM	ORE	
	Funeral Director		5. Social Security Number 216-12-3864 6. Sex 1 □ M 2 ☐ F 86	birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 08/09/1918 MARYLAND			
	and ₩		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Lo	cation					10d. Inside City Limits	
	Manyl f sho	5	MD BALTIMORE SI	PARK	S					1 Yes 2 No	
	the 28a-	Director	10e. Street and Number		10f. Zip Code			10	g. Citizen of What	Country?	
	3e or		15043 PRICEVILLE RD		2115	2			USA		
	death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. \	Was Decedent of f Yes, specify Cul	Hispanic Orig	gin? (Spec	cify Yes or No-		nerican Indian,	
9	or the		1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give		r Yes, speciny Cui I⊡ Yes 2 X No		, Риепо н	(ican, etc.)	Black, Wi		
93	72 hours after death with the Maryland Instural; or ttems 23e or 28e-t show Sical Examitrat court be notified at	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:		1 1 1 6 5 2 20 1 N C	э эрвспу.			Specify: W	HITE	
ر ک	72 h 'natu	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	(Give	lent's Usual Occu kind of work done	e during most	of workin	g 1	6b. Kind of Busines	ss/Industry	
12	within ne. than	mpl	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retire EWIFE	9đ)			номема	KER	
d 2	Hygie ther ther		17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle, N	laiden Sumame)		
Maryland 21215-0036	ld be ental ked o	To Be	MICHAEL ADAM SMITH			AGNE	S M.	GRIFE	IN		
Z Z	shoul nd Me mari	F		9b. Mailin	g Address (Stree				City or Town, State	, Zip Code)	
ž	alth a		ROBERTA IBER (DAUGHTER)	1504	3 PRIC	EVILL	E RI	. SPAF	RKS,MD.	21152.	
Je,	ss 1 a of Hei item		come		sition (Name of natory or other pla	ace)	Da	ate 2	0c. Location - City	or Town, State	
E	Page nent c ant: If arry or		1 MBurial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify)	-			04/2	2005 F	PARKVILL	E,MD.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23e or 28a-f show amy injury or other traumatic event, in a Marical Examiner must be notified at sone.		21. Signature of Saneral Service Licensee		. Name and Addr				15 00		
_	207 2 2		William C. Lange						IS CO. MD. 211		
Į.	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	7	er the mode of dy			respiratory arre	st,	Approximate Interval Between Onset and Death	
	Examiner		Due to (or as a consequence	ce of):							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):							
	cuted	Examine	that initiated events								
oʻ	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence	ce of):							
8760,	death certificate be executed e attending physicien and od for use as the burial-transit	lical	d								
x 68	death certifica attending ph d for use as t	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy						204 0-4-4		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 1 Live birth 2 Fetal dec		Ectopic pregnand Other (specify) _	су			23d. Date of d Month	Day Year	
Ö	that the de ed by the detached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	-	(apoony) _						
<u>a</u>	iaw requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause g	iven in Part I.		23e. Did tob	acco use contribute	to the cause of death?	
rds,	quires n sign							1 🗆 Ye:	3 □	Probably 4 Unknown	
Record	aw requir s been sl	ompleted						24a. Was an		autopsy findings available	
	0 - 0	E O						autopsy perform		completion of cause of	
Vital	icien: Th certificate ector, pag	BeC	25. Was case referred to medical			26. Place	of Death	(Check only one	_*		
of V	d is	10	examiner? 1 Yes 2 Yo Hospital: 1 Inpatient 2 ER/	Outpatien	t 3 DOA	ther: 4 🗆 Nui	rsing Hom	e 5 Resider	nce 6 Other (Sp	pecify)	
		on:	27. Manner of Death 28a. Date of Injury 28b. 1 Natural 5 □ Pending (Month, Day Year)	. Time of Injury	Wo			8d. Describe how	v injury occurred		
sio	r Attending er death. rector: Afte by the fune	cati	2 Accident investigation			∃Yes 2 □1	-	06 1			
Division	or Attendated death Director:	Certification:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office	•	28	City or Town,		Rural Route Number,	
	purs a		29a. Certifier Certifying Physician: To the best of my knowled	ine death	occurred at the t	time date and	d place, at	nd due to the car	ise(s) and manner	as stated	
	To the Hospitel or a within 24 hours after To the Funerel Direct completely filled in b	edical	(Check only 2 Medical Examiner: On the basis of examination one) and manner stated.								
	To th withir To th comp	Me	29b. Signature and Aitle of certifier			ise number	, ,	29	d. Date signed (Mo	oth, Day, Year)	
	. 1	/	126 HNOT MES		103	684	16	2	ANUMY	03, 2005	
0	16		30. Name and address of person who completed cause of death (Item 23a							.)	
() ('		BERNARD RAVITZ M.D. 5601 LO	CH F	RAVEN B	LVD.	SUIT	TE 208A	BALTO.	,MD.	
	Sta Registr		31. Date filed (MAN) Day VSar/2005	Span							

			1 - State of Maryland / Departm	nent of Health and M cate of Death	ental Hygie	4004	41936
	Physicia	210	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	- /Medic		Shabakah Alexander		December		5:15 P M
	Examin	er		City, Town, or Location of Death		4c. County of Death	
			Washington Adventist Hospita1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Takoma Park Inder 1 Year If Under 24 Hrs.	8 Date of Birth	Montgomer	
	Funeral Director		212-69-6393 1 □ 2 □ F 20 Yrs. Mor	nths Days Hours Min.	8. Date of Birth (Month, Day, You December		oface (State or Foreign htry)
	ס		Usual Residence of Decedent		December		
	arylar show	_	10a. State 10b. County 10c. City, Town or Location 10c. Ci	11e			0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M.	ecto		4.75- O-de	10-	. Citizen of What Cour	
	with t	Funeral Director		f. Zip Code 20782	log.		ntry ?
	leath	era			cify Yes or No-	Grenada 14. Race - America	can Indian,
ထ	of iter	F	1 X Never Married 2 Married 1 ☐ Yes 2 X No	Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
ğ	rel', c	1 by	3 ☐ Widowed 4 ☐ Divorced	es 2 No Specify:		Specify: Blac	ck
5-0	72 h "netu	etec	(Specify only highest grade completed) (Give kind	Usual Occupation of work done during most of workin OT use retired)	n <i>g</i> 161	b. Kind of Business/In	dustry
21215-0036	within 72 hours after death with the Maryland ene. then "returel", or items 23e or 28a-f show the Madrel Examination and be notified at	Completed	Elementary/Secondary (0-12) Coflege (1-4or 5+) Stude	·			
<u>م</u>	filed Hygi other ent, I		17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	iden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23e or 28a-1 show entry or other treumatic event, the Medical Examiner must be notified at once.	To Be	Anthony Browne	Shirma A	lexander		
lary	2 short and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	dress (Street and Number or Rura	l Route Number, C	ity or Town, State, Zip	Code)
, Z	and ealth m 27			holson St # 202			
altimore,	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crematory	or other place)		c. Location - City or To	
Ē	rtmen rtmen rtent: njury		'4 □Donation 5 □Other (Specify) 21. Signature = Funeral Service Licen 22. Nan			ndover,Mai	
Ba	permit. Departr Importe eny inju		21. Signatura Philipid 39 VIII Elegation 22. Nati	ne and Address of Facility J. Landover Road	B. Jenkin Landover	ns Funeral	Home
			23a. Part1. Enter the disease, or complication that caused the death. Do not enter the				Approximate
6	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Omilant	MILE		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	A11-119	~/>		
В	Examiner		Sequentially list conditions b.	· •			
	sit sd	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				
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687	ificate g phy: as the	Physician/Medical	0.				
Box	leath certifica attending pl	M/m	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ecto	pic pregnancy		23d. Date of delive	
	ne deat the att	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Othe	ar (specify)		Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown	in a superior in Book I	230 Did tabas	co use contribute to the	an agus of doath?
	gn ga	by	Part If. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	1 Tes	2 No 3 □ Prot	
Vital Records,	w requir been si should	Completed			24a. Was an	\wedge	
Rec	he lav	ldmi			autopsy performed	prior to co death?	psy findings available mpfetion of cause of
tal	sicien: The lav certificate has rector, page 2	e Co	25. Was case referred to medical	26. Place of Death	/	No 1 ☐ Yes	217 No
>	ysicie is ceri	0 8	examiner? / Hospital: /	Other		e 6 □Other (Specif	y)
n of	Attending Physicien: r death. sctor: After this certific by the funeral director.	T :uc	27. Mannier of Att 28a. Dite of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
Siol	eath. or: Al	catle	Accident investigation M				
Division	l or Attendater deatl Director: I in by the	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	il Route Number,
	Hospitel 94 hours a Funeral (29a. Certifier 1 € Certifying Physicien: To the best of my knowledge, death occu	urred at the time, date and place a	and due to the caus	co(s) and manner as s	tated
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h, completely filled in by the funeral director, page	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investig one)	ation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
)			NUGUSIE	DUSYT	1	12/	16/04
2			30. Name and a dress of per in o completed cause of death (Item 23a) (Type, Print)	- Wash	inal.	(1)	1.11
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1000	TON	DIV	enhit My
	Registr		DEC 2 1 2004 DEC 2 1 2004 DEC 2 1 2004		_		

			1 - State Registrar		artment of Health and N rtificate of Death	Mental Hygierne 0 04 4 1937
I	Physic		1. Decedent's Name (First, Middle, Last)	FRION		2. Date of Death Month Day Year 7074 2. Date of Death Annual Street 2. Date of Death Annual Street 3. Time of Death Annual Street 4. Cop M
	/Medi Examii		4a. Fecility Name (If not institution, give street Howard County General	and number)	4b. City, Town, or Location of Death Columbia	700
	Funeral Director		5. Social Security Number 6. Sex 1	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 26, 1915 9. Birthplace (State or Foreign Country) Pennsylvania
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo		10d. Inside City Limits
	the Mar 28a-fs	Funeral Director	Maryland Howard 10e. Street and Number		lumbia	1 ☐ Yes 2 No
	eath with	eral Di	5400 Vantage Point R		21044	United States
960	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be motified at	by	1 Never Married 2 Married 1	led Forces?]Yes 2√ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1☐ Yes 2【XNo Specify:	pecify Yes or No- Prican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	n 72 h	Completed	15. Decedent's Education (Specify only highest grade comp	leted) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b. Kind of Business/Industry
	filed with Hygiene Ither tha		Elementary/Secondary (0-12) Co 12 17. Father's Name (First, Middle, Last)	lege (1-40r 5+)	stered Nurse	Yater Clinic e (First, Middle, Maiden Sumame)
Maryland	should be and Mental I marked o	To Be	Benjamin Fulton Pa	yne, Jr.	Olive C	lare Victoria Wilson
	and 2 shi Balth and n 27 is m		19a. Informant's Name/Relationship (Type, Pri William J. Anderson —		ng Address <i>(Street and Number or Rur</i> 5 Pretoria Drive S	al Route Number, City or Town, State, Zip Code) Silver Spring, Maryland 20904
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any niury or other traumatic event, Ite Manne.		20a. Method of Disposition 1 ☐ Burial 2 【★Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cometery, creating Metropol:	matami'as athau alaaal	Date 20c. Location - City or Town, State /14/2004 Alexandria, Virginia
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee Dorold V. Bag	watt 13	Name and Address of Facility Dhald V. Borgwardt 100 Powder Mill Ro	Funeral Home, P.A. bad Beltsville, Maryland 20705
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition	that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death
	/Medical- Examiner		Sa	ue to (or as a consequence of):	obstructive pul	monary Diseasement teas
	cuted od	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of):		
68760,	ficate be executed physician and ts the burial-transit	edical Exa		ue to (or as a consequence of):		
Box 68	eath certifica attending ph for use as th	an/Med	200. Was decedent pregnant	os, outcome of pregnancy Live birth 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery
o.	the d y the	Physician/M	1 Yes 2 No.		Other (specify)	Month Day Year
ords, P.	law requires that as been signed b 2 should be deta	by	Part II. Other significant conditions contributing	g to death but not resulting in the ur	iderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Northead Probably 4
of Vital Records,	9 L B	ompleted	DEMENTIA			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
/ital	ysician: Th iis certificate director, pag	Be Co	25. Was case referred to medical examiner?		26. Place of Death	1 Yes 2 No 1 Yes 2 No
of	Q 50 X	n: To	1 ☐ Yes 2 No Hospital 27. Manner of Death 28a.	1 patient 2 ☐ ER/Outpatient Date of Injury 28b. Time of		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Division	Attending Isr death. ector: After by the funer	ication	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) Injury	M 1 Yes 2 No	
Di	ital or Attenders after deatles al Director:	Certification:	4 Homicide determined 286.	Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	Z Medical Examiner: On	To the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	To the I	M	29b. Signature and title of sertifier	13	29c. License number	29d. Date signed (Month, Day, Year)
!	9		30. Name and address of person who complete	cause of death (Item 23a) (Type, F	Print) KENNETH	GEHIAD
	Sta	è	31. Date filed (Month, Day, Year)	32. Registrar's Signature	ALTIMORY IN	10212 0
	Registr		DEC 16 2004	Server &	Sparker	

			For State Registrar	State of N	Maryland / Depa Cea	artment of H			2004	41938
П			1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physici /Medic		Muhammad Abdul	-Rauf				Dec. 11,	Day Year 2004	7:11 P M
	Examin		4a. Facility Name (If not institution,	give street and number	er)	4b. City, Town, or	Location of Death		4c. County of Dea	ath
			Suburban Hospi	tal		Beth			Montgom	nery
	Funeral Director		087-44-3536	.Sex 7.7 12 M 2 ☐ F	Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Dec. 27,	earl (rthplace (State or Foreign Country) Egypt
	pud *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ncation				10d. Inside City Limits
	sho ed at	ក	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	~ m ~ wii	Bethesda					1 X Yes 2 No
	the N	ect	MD Montgo	Jille L y	Detnesda	10f. Zip Code		100	J. Citizen of What C	
	with	2	5911 Mass. Ave.				816	1.09	US	
	ns 23	era	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.			ecify Yes or No-	14. Race - Am	
10	riter	Funeral Director	1 ☐ Never Married 2 Marrie	Armed Force	ŽINO I	Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Wh	ite, etc.
030	at', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:	1□Yes 2ሺMNo	Specify:		Specify:	White
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Examinat must be notified at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation furing most of work	ina 16	b. Kind of Busines	s/Industry
21	within one one one one one one one one one on	nple	Elementary/Secondary (0-12)	College (1-4c	or 5+)	kind of work done of DO NOT use retired,				
21	ygier ygier th	Co		5+		Islamic		(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Islamic	Faith
und	be fill H and other	Be	17. Father's Name (First, Middle, La	ist)				e (First, Middle, Ma	iden Sumame)	
Maryland	12 should be filed within 'n and Mental Hygiene.'' 7 is marked other than "'Iraumatic event, It e Med	2	Muhammad Abd 19a. Informant's Name/Relationship	Time Drint	10h Maili	a Address (Ctrost		lhudeiry al Route Number, C	Situati Taura State	Ti- Code)
Ma	d 2 si th an 7 is r		Buthayna Abdul-I					sda, Mary		
é,	1 an Heal Iam 2		20a. Method of Disposition	(aul/wile	20b. Place of Dispo	sition (Name of		Date 20	c. Location - City o	
20	ages ant of t: # if		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		19	matory or other place	Dec			MD
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event. It is Madical Examinating must be notified at once.		21. Signature of Funeral Service L	- A		on Nat. Co 2. Name and Addres	s of Facility Do	Vol Funer	itland, al Home	MD
B	Deparenti Imporanti any ir		Henry	Fort			2222 Washi	Wisconsin ngton, D.	Ave N	. W .
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caus	sed the death. Do not en	er the mode of dying				Approximate Interval Between
	Physician		Immediate Cause (Final	. 1		م بناء	In. IA C	~ Qu	o tuce	Onset and Death
	/Medical		disease or condition resulting in death)	a. Abcon Due to (or	as a consequence of):	or the p	(Neo 17 a)	m Ru	1	-
	Examiner		Sequentially list conditions	b						
	p #	Iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence of):					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	cate be executed physicien and the burial-transit	E		Due to (0)	as a consequence of):					
	physics the l	dical		d				· · · · · · · · · · · · · · · · · · ·		
9 X	death certific e attending p d for use as	/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnancy				23d. Date of de	alivery
Box	atter after 1	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant	at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
P.O.		hysl	9 Unknown	9□ Unknown	1					
	requires that the een signed by th hould be detache	by PI	Part II. Other significant condition	s contributing to death	h but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
rds	w require been sig should b	ed t						1 🗌 Yes	2 No 3 ☐ F	Probably 4 Unknown
Records,	> 0 to	plet						24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
R	The lavate has	Completed						performe	d? death?	
Vital	ysician: Th	Bec	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of V	di is	2	1 ☐ Yes 2 ☑ No	Hospital: 1 1npa			er: 4 🗆 Nursing Ho	ome 5 🗆 Residenc		ecify)
ū	ng fter nei	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		njury 28b. Time o Day Year) Injury	Work	(?	28d. Describe how	injury occurred	
Sio	Attanding r death. actor: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	t be	Asiana Asiana Asiana		Yes 2 □ No	206 Lanatina (Ctua	at an al throughour as f	Dural Claude Alvertage
Division	or Al	Certification:	4 Homicide determin	ad 286. Place of	Injury - At home, farm, streetc. (Specify)	eet, factory, office		City or Town, S	er and ivumber or r State)	Rural Route Number,
1	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	S E	29a. Certifier 1 V Certifying	Physicien: To the be	est of my knowledge, deat	h occurred at the tim	e, date and place	and due to the caus	se(s) and manner a	as stated.
	e Hos 24 h e Fur letely	edical	(Check only 2 Medicel E.	xeminer: On the basis	s of examination and/or in	vestigation, in my or	pinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Mor	nth, Day, Year)
•	7		1 cul	pen	- MD	0005	0485		12 - 11 -	-04
			30. Name and address of person w	ho co pleted cause o	of death (Item 23a) (Type,	Print)				`
			Ivan O. Rosas, I		Bethesda, N	1D 20892				
K	Sta		31. Date filed (Month, Day, Year)	32. Regi	istrar's Signature	Sparks				
la.	Registi	ar	DEC 14	ZUU4 /	1	Jago vario				

DHMH 17 Rev 1/2001

RAUF, Mahaummed 12/11/04 19:11

Please Type or Print in Black Indelible Ink.	. Ensure All Copies Are Legib
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			For State Registrar	State of M	Maryland		artment <i>tificate</i>					,00	2004	61930
1	Physici		1. Decedent's Name (First, Middle,	Last) eon Louis	ANDEL	IAN					. Date of Dea Month	ath Day		3. Time of Death 9:45 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and numbe	or)		4b. City, To	own, or	Location of			1	County of Deat	
			Suburban Ho					ethe					Montgom	
	Funeral Director		5. Social Security Number 227-01-9431	. Sex 7. <i>i</i> 1 X M 2 ☐ F	Age (In yrs. la 89	ast birthday) Yrs.	If Under 1 Months	Days	If Under:	Min.	Date of Birti (Month, Day Nov . 1	h /, <i>Year)</i> 1 14	9. Birth Co 915 Vi	nplace (State or Foreign untry)
	D		Usual Residence of Decedent					1		1	NOV. 1.	L, L	313 VI	rginia
	ehow	ō	10a. State 10b. County Maryland Montg	omery	10c. City	Town or Lo	_{cation} hesda							10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	28a-f	rect	10e. Street and Number	Omer y		Dec	10f. Zip C	ode				10a. Citiz	zen of What Co	
	th with	al DI	7401 Westlake	Terrace #7	14				20817	7			ted Sta	
036	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiene. Item 27 is marked other then "naturel; or liems 23a or 28a-f ehow other treumatic event, the Madical Examiner mout be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Yes 25 If Yes, Give Year or Dates	s? ∑No		Was Deceder f Yes, specifi 1 Tes 25		spanic Origin, Mexican Specify:	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ame Black, White Specify: wh	e, etc.
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	dent's Usual kind of work DO NOT use	Occupa done d	tion uring most	t of working		16b. Kin	nd of Business/l	ndustry
21215-0036	within ane. then "	Completed by	Elementary/Secondary (0-12)	College (1-4c	or 5+)	_	10 NOT use		,]	Liquor	
d 2	e filed Il Hygie other vent, II	Be Co	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name (First, Middle,	Maiden S	Sumame)	
/lan	uld be Vental Nrked o	To B	Max Andelma	n					Re	ebecca	a Steir	berg	g	
altimore, Maryland	2 sho		19a. Informant's Name/Relationship				-						Town, State, Z	ip Code) 20817
e,	1 and Heelth em 27	1	Phyllis Andelma 20a. Method of Disposition	ii, wile	20b. Pl	ace of Dispo emetery, cren				_	L4, Bet		cation - City or	
mor	Pages ent of nt: If it		1 Surial 2 Cremation 3		10	metery, cren ean Me				12/13/	/ 04		ey, MD	,
alti	permit. Pages Department of H Important: If ite any injury or ot	-	21. Signature of Fureiral Sarvice (Li			22	. Name and	Address	s of Facilit	y	ıneral		-	
8	W-EVAI		23a. Part1. Substitute disease, or construction of the disease	omplications that caus	ed the death		54 Car er the mode	rol of dying	1 St					20012 Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	aDue to (br	as a contequ		Syau	Wow	l					
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):										
8760,	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or a	as a consequ	ence of):								
9	tificati ig phy as the	ledle		- V.		770								
.O. Box	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	Ectopic preg Other (spec					2:	3d. Date of deliv	very Day Year
rds, P	law requires that as been signed b 2 should be deta	by	Part II. Other significant condition	s contributing to death	but not resu	lting in the ur	nderlying cau	ise give	n in Part I.			bacco us es 2□		the cause of death?
of Vital Records,	The ate has page	Completed									24a. Was a autops perform	sy med?	24b. Were aut prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
Vit.	Physicien: Th this certificate ral director, pag) Be	25. Was case referred to medical examiner?	Hospital:		-0.0		Otho			Check only or		Flav. 10	2.
on of	Attending Physic death. ector: After this by the funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Ir (Month, L	itient 2 E njury Da <i>y Year)</i>	28b. Time of Injury		c. Injury Work	at	28	d. Describe h		Other (Spec	ify)
Division	el or Attendi s after death al Director: A ed in by the f	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 289. Place of	Injury - At hor etc. (Specify,	me, farm, str	eet, factory, o	office		28	f. Location (S City or Town	treet and n, State)	Number or Rui	ral Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be taminer: On the basis and manner	of examinati	vledge, death on and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, and th occurred	d due to the c at the time, d	ause(s) a late and p	and manner as place, and due	stated. to the cause(s)
	To the h within 24 To the F	Σ	29b. Signature and title of certifier				1.77	-	number	207	2		signed (Month)	, Day, Year)
,	5		muy					1100)613	706		12	(11/2004	
			30. Name and address of person was Atul Rohatgi.)r iv	e. Ro	ockvi1	.1e, MI) 20) <i>(</i>)850	
	Sta	te	31. Date filed (Month, Day, Year)	32 Regi	strar's Signati	Uro A	A .		-, 110	, 0.10 11	, m			
	Registr	_	DEC 14 20	104	رمور	P	Sport	es/						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Datth 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 8, 2004 3:20PM Dec. V. ARCY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 8. Date of Birth (Month, Day, Year)
Dec. 5, 1917 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Michigan Yrs 87 Director 372-10-6326 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28e-f show r than "natural", or Items 23a or 28e-f shov the Madical Evaniner must be notified at 1 XYes 2 No Director North Bethesda MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20852 10900 Round Table Ct Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home 9th Domestic Pages 1 and 2 should be filed w trent of Health and Mental Hygier tant: If item 27 Is marked other th jury or other treumatic event, It. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Victoria Cupka Kolasa Felix ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Pulley -Daughter 10900 Round Table Ct N. Bethesda, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State permit. Pages
Department of
Important: If it
eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/10/04 Garden City, MI `4 ☐ Donation 5 ☐ Other (Specify) Hadwig Cem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St Rockville, MD20850 COLIFE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION hours Priysician /Medical Due to (or as a consequence of) Examiner years CORONARY ARTERY DISEASE S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed CARDIOGENIC SHOCK physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical d. as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No ō 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by 1 Tyes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 **X**No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0058965 Dec. 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119, Rockville Pike #100 Rockville, MD 20850 Salma Khemayn, MD32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 4 2004 Registrar DEC

			1 - For State Registrar	State of Marylar		rtment of H			ne 004	41941
	Physicia	an	1. Decedent's Name (First, Middle, Last)	ALISI				2. Date of Death Month	Day Yea	3. Time of Death p 15 15 M
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	rta/		Location of Death	12	4c. County of D	,
	Funeral Director		5. Social Security Number 6. Sex 227-75-69-16	7. Age (In yrs.	, last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9.16 -53 G	Birthplace (State or Foreign Country) Hana
daath with the Marvland	-f show fied at	tor	10a. State 10b. County		ity, Town or Loc	ndria			<u> </u>	10d. Inside City Limits 1
ăi eti	a or 28e	Director	10e. Street and Number	SIZZ	7	10f. Zip Code	214	10g	. Citizen of What	
ر بو ا	or Items 23	y Funeral	1 ☐ Never Married 2 🛣 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 D No If Yes, Give		as Decedent of H Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		merican Indian, hite, etc.
ORC/ON d 21215-0036	"natural", edical Ex	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade	Year or Dates:	16a. Decede	nt's Usual Occup	ation during most of working	ng 16	b. Kind of Busine	Slack ss/Industry
2 <i>RCL</i> d 2121	Hygiene. ther than int, the M	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	C	hef	18. Mother's Name			rant
Maryland	narkad o markic ava	To Be	1	umadu	19h Mailing	Address (Street	Ama and Number or Rura	Ach	aah	Zin Codel
7	of Health a item 27 is other train		Sarah AKISI 20a. Method of Disposition	(Wife 20b.	907	1 1-1	oon St.	#B2	A lex	dra 16 22319
AHIMORE	Department of Important: If any injury or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State	etropo	I, fan Cre Name and Addres	m. 12-1	6-04 F	Hexand neral t	tone
	, ,		23a. Part1. Enter the disease, or complishock, or hear vailure. List only on	cations that caused the deale cause on each line.	th. Do not enter	the mode of dyin	brick 5+ g, such as cardiac o	A PEX r respiratory arrest	, VA Z	Approximate Intervat Between Onset and Death
	hysician /Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	quence of):	doana	(i his			isko
	- 4	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Ous to for as a consec	quince of):	4 4	seose			77
18760,	physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Hypert			all'se			Yrs.
Box 68	within 24 hours after death. To the Funaral Diractor: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 □ E	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
P.O.	ed by the detacher		9 Unknown Part II. Other significant conditions con	9□ Unknown tributing to death but not res	sulting in the und	lerlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ords	been sign	eted by						-		Probably 4 Unknown
al Rec	icate has r. page 2 s	Completed							prior t death	autopsy findings available o completion of cause of ? es 2 No
Vit	certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	ospital:	ED/Outpotions	3CT DOA Othe	26. Place of Death		, EQ. (2)	
Division of Vital Records,	ath. or: After this ne funeral d	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 Indising Hon	ne 5 🗌 Residenc 8d. Describe how		pecify)
Divis	rs after de ral Diracto led in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stree fy)	et, factory, office	2	8f. Location (Stree City or Town, S		Rural Route Number,
Hoson and	in 24 hou he Funa pletely fil	edical	29a. Certifier 1	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the timestigation, in my or	e, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	withi To tl	M	29b. Signature and title of certifier CPMLAAM			29c. License			Date signed (Mo	
al (3		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type, P		·			
	Sta Registr	_	31. Date filed (Month, Day, Year) DFC 1 7 2004	2. Registrar's Signa						

For State Registrar	State of Maryland / Depa	artment of Health and I	Mental Hygier	2001 1.101.2
1. Decedent's Name (First, Middle, Last) William Ark, Sr	•		2. Date of Death Thereh 22 2	28,04 Year 0017 A M
/Medical Examiner 4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	1	4c. County of Death
ICU Memorial Ho	~	Cumberland If Under 1 Year If Under 24 Hrs.		Allegany
Funeral Director 5. Social Security Number 6. Sex 1 C	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye SEPT 14 1	9. Birthplace (State or Foreign Country) 926 WEST VIRGINIA
10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
MARYLAND ALLEGANY	RAW	LINGS		1 ☐ Yes 2Å No
MARYLAND ALLEGANY 10e. Street and Number 20306 SW NcMULLEN 11. Marital Status 1 \(\triangle \text{New Married} \) 2 \(\triangle \text{Married} \)	HIGHWAY	10f. Zip Code 21557	10g.	Citizen of What Country?
11. Marital Status	12. Was Decedent Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
with the Maryland ALLEGANY 10a. State 10b. County MARYLAND ALLEGANY 10b. Street and Number 23 o c 58-1 show 10b. Street and Number 200306 SW NcMULLEN 11. Marital Status 1 Divorced 15. Decedent's Edu (Specify only highest grade (Specify only highest grade Elementary/Secondary (0-12) 7	1 XYes 2 No	r Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ∰No <i>Specify:</i>	o Hican, etc.)	Black, White, etc. Specify: WHITE
3 Widowed 4 Divorced 15. Decedent's Edur (Specify only highest grade (Specify only highest grade 7) Elementary/Secondary (0·12) 7	cation 16a. Dece	dent's Usual Occupation	king 16b	. Kind of Business/Industry
15. Decedent's Education of the control of the cont	College (1-4or 5+)	kind of work done during most of wor DO NOT use retired)		NAMBUAMTON
N p o a .		ARPENTER 18. Mother's Nan	ne (First, Middle, Maid	NSTRUCTION den Sumame)
Tr. Father's Name (First, Middle, Last) ALBERT RICHARD ALBERT RICHARD ALBERT RICHARD ALBERT RICHARD Albert Richard 19a. Informant's Name/Relationship (Tv.	ARK	FANNI	E ANN BOLY	ARD
DAVID ARK / SON		ng Address <i>(Street and Number or Ru</i> BUCK SKIN LAKE DR		
U − I a = 20a Mathod of Disposition	emoval from State	natory or other place)		. Location - City or Town, State
Section 3 Description 3 Descri		SPRINGS CEM.		DTOWN, MD W. MAIN ST.
en med du la mana de l				OSTBURG, MD 21532
shock, or heart failure. List only or				Approximate Interval Between Onset and Death
/Medical /Me	Multiple trauma w Due to (or as a consequence of):	ith medical compl	ications	20 days
Examiner Sequentially list conditions				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
resulting in death) Last	Due to (or as a consequence of):			
	l			
The second of th	3c. If yes, outcome of pregnancy			23d. Date of delivery
The standard of the standard o		Ectopic pregnancy Other (specify)		Month Day Year
Dept is dept in the dept in th	ntributing to death but not resulting in the u	ndarking eques given in Part I	23e Did tobacc	to use contribute to the cause of death?
Part ii. Other significant conditions cor	The string to seem seem to the string in this si	identified datase given at the artic		2 No 3 Probably 4 Unknown
The law requires that the death certificate cate has been signed by the attending physical by th			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
		26 Place of Dea	1 ☐ Yes 2 X	
examiner?	lospital: 1 Inpatient 2 ER/Outpatien	Orbert		6 ☐Other (Specify)
A G of the part of Death of De	28a. Date of Injury (Month, Day Year) Dec 2 2004 2018	P 28c. Injury at Work?	28d. Describe how in	njury occurred
Natural 1 Director Direct	28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 No	28f. Location (Street	and Number or Rural Route Number,
Hoors after death. The special of t	building, atc. (Specify) Highway	oot, lastery, onlos	McMullen	Hgy Cresaptown Md
29a. Certifier 1 Certifying Physical Components of the Fundant of	sician: To the best of my knowledge, death ner: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
equitive of certifier 29b. Signature and title of certifier	N	29c. License number	!	Date signed (Month, Day, Year)
O oul	moleted cause of death (from 33a) (T	D09157	Dec	22 2004
Paul Snow M.D. I		2rd St Cumberland	Md 21502	
State Registrar 31. Date filed (Month, Day, Year)	32. Registrar's Signature	books		

			1 - For State Registrar	State of Ma	-	-	artment of F			F	leg. No. 2	101	
	Physici /Medic Examin	al.	Decedent's Name (First, Middle, Last A. Facility Name (If not institution, give	Benjami	n Paul	В	Blaine, J			2. Date of Dea Month Decembe	er 16,	Year 2004 y of Death	3. 11 melor beats 3
	Funeral	9	8306 Verona Drive 5. Social Security Number 6. Se		(In yrs. last birt	hday)	New Car	If Under	24 Hrs.	8. Date of Birth		9. Birtho	eorge's
	Director		Usual Residence of Decedent]M 2□F	01	Yrs.	Months Days	Hours	Min.	uly 09	1923	Wash	ington DC
	he Marylar 28a-f show ciffied at	Director	Maryland Prince G	eorge's	10c. City, Towr	or Lo	New Co	arrol	lton	· · · · · · · · · · · · · · · · · · ·	10 - 03		0d. Inside City Limits 1 ☐¥es 2 ☐ No
	h with 23a or	al Dir	8306 Verona Drive	<u>:</u>			207	84			10g. Citizen of	What Cour USA	nry?
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel; or items 23a or 28a-f show or other traumatic event, the Midical Exam. An inust is notified at	by Funeral	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1√2¥es 2 □ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	fispanic Ori an, Mexicar Specify:		cify Yes or No- Rican, etc.)		ce - Amend ick, White, fy: Wh	
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during mos d)		_	16b. Kind of B		
d 21	filed w Hygier other tl	ക	17. Father's Name (First, Middle, Last)	4+		Tr	ansporta			Itant (First, Middle,		rivat	e
ylan	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the M	To B	Benjamin P. Blai	ne					nne W				
Mar	nd 2 should lith and 27 is m		19a. Informant's Name/Relationship (T) Eileen Blaine (Wi				ng Address <i>(Street</i> Ve ron a Di						
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 iny or other tra		20a. Method of Disposition 1 XBurial 2 Cremation 3 F	Removal from State	20b. Place of	Dispo	sition (Name of matory or other place	- 1			20c. Location		
i ii	it. Pa rtmer rtent: njury		 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Lidens 	4	Resur		tion Ceme	_	- · · · · · · · · · · · · · · · · · · ·			ton, I	
ä	permi Depa impo eny ii		Kullan ,	Jouls		9	013 Annar	∞ lis	Road	, Lanha	m MD 2		
	Pnysician /Medical Examiner		23a. Park Enter the disease, or como shock, or heart failure. List only of disease or condition resulting in death)	a	the death. Do ne.	5	er the mode of dyin	ng, such as	cardiac or	respiratory arr	est,	. 9	Approximate Interval Between Onset and Death 3 days
8760,	icate be executed physician and s the burial-transit	Ilcal Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	a consequence o				• .				
.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death		Ectopic pregnancy Other (specify)	,				ate of delive	ny Day Year
rds, P	iw requires that the s been signed by th s should be detache	by	Part II. Other significant conditions co		it not resulting in	the u	nderlying cause giv	en in Part I.		23e. Did tol	_	tribute to th	e cause of death? ably 4 Unknown
Vital Record	The law ate has b page 2 st	Completed								24a. Was a autops perform	ned?	prior to con death?	osy findings available inpletion of cause of
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	lospital: 1 Clinnatias	nt 2□ER/Out	nation	t 3C DOA Oth			(Check only on		os (Cassite	
ion of	ding h. After fune	ertification; T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day			28c. Injur Wor		28	Bd. Describe ho			9
Division	spitel or Atten ours after deat lerel Director: filled in by the	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, far . <i>(Specify)</i>	m, str	eet, factory, office		28	Bf. Location (St City or Town	reet and Numb n, State)	ber or Rural	Route Number,
	24 h	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination and	, death	occurred at the tin vestigation, in my o	ne, date an pinion, deal	d place, ar	nd due to the ca	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10			29c. Licens	e number		2	9d. Date signe		
þ	(m)		39. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Туре,	Print)	600	13_			18/0	7
	(10)	·	Ledman Mostghir 31. Date filed (Month, Day, Year)	+ 22 Decistes	do Cianatura		P. rkway	,602	enbi	IT, MC	1207-	20	
<u>.</u>	Sta Registr		DEC 2 1 2004	Black	A Source	oction.							

			Flease	State of Maryland			-	•	
			For State Registrar	State of Maryland	Certificate of L			. No. 2004	1. 101.1.
			Decedent's Name (First, Middle, Last)	^ .	-		2. Date of Death	. No.L. O O ap	3. Time of Death
	Physici /Media		Phillip	X. Brusley	J_r		Dec.	Day Year. 16 2007	9:58 FM
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or	Location of Death		4c. County of Death	12
				ommunity He	osp. Chi	everly		Prince	Georges
	Funeral		5. Social Security Number 6. Sex	7. Age (in yrs. last	t birthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		
	Director		Usual Residence of Decedent	0 /			Mar 30	1941 1Em	nsylvania
	how how		10a. State 10b. County	10c. City, 7	Town or Location	11			10d. Inside City Limits
	Be-f	cto		rearges U	pper Mar	(boro			1 ⊡Yes 2 □ No
	with the	Dire	10e. Street and Number	not t	10f. Zip Code	Maa	10g	. Citizen of What Cou	ntry?
	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28e-f show of other than "natural", or items 23a or 28e-f show event, the Medical Examilian mines the multiled at	by Funeral Director	13701 Fcal (2. Was Decedent Ever in U.S.		722	ity Yes or No.	14. Race - Ameri	can Indian
(0	riter d	Fu	1 Never Married 2 Married	Armed Forces?	13. Was Decedent of His If Yes, specify Cubar		ican, etc.)	Black, White,	etc.
215-0036	ours a	t by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	Black
2-0	"natu	Completed	15. Decedent's Educ (Specify only highest grade	cation 1 completed)	16a. Decedent's Usual Occupa (Give kind of work done di	uring most of workin	9	b. Kind of Business/fr	ndustry
2121	within ene. than	mp	Elementary/Secondary (0-12)	Coilege (1-4or 5+)	Program 5	necialie	<i>i</i>	Dist G	overnment
	filed withi Hygiene. other than ent, the N		17. Father's Name (First, Middle, Last)	2 113	riegram, s	18. Mother's Name	(First, Middle, Ma		
a	ould be Mental arked o	To Be	Phillip X. Beas	ley Sr.		Eliza	beth 1	Robinson	
Maryland	s 1 and 2 should f Health and Men item 27 is marke other traumatic	0 9	19a. Informant's ame/Relationship (Typ	00, P t)	19b. Mailing Address (Street a	nd Number or Rural	Route Number, C	ity or Town, State, Zi	o Code)
	1 and 2 Health em 27 l		Darlene Suggs	Frances		ourt U	per Mai		1 20722
Baltimore,	0 0	1 3	20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Re	200	e of Disposition (Name of etery, crematory or other place) Da	l(e 20	c. Location City or T	
≣			'4 □Donation 5 □Other (Specify)	1-7	t. Lincoln	Vec 2	2 2004	Brentwee	d, Ma
Bal	permit. Departr Importa any inju		21. Signature of Funeral Service License	7/2	22 Name and Address	lliams F	uneral	Service	20 70013
			23a Part1. Enter the disease, or complic	cations that caused the death.	Do not enter the mode of dying	such as cardiac for	respiratory arrest	shington	Approximate
-	Physician		snock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	V			00 (000)	Interval Between Onset and Death
-	Medical		disease or condition resulting in death)	S Huse ! / Due to or as a consequen		on-Small	cell Lun	ganer_	6 months
t.	Examiner		Sequentially list conditions						6 / 10
	po iii	iner	Sequentially list conditions, 1.y, leading of mediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequen	nce of):				
	and and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequen	nce of):				
760,	eath certificate be executed ettending physician and for use as the burial-transit	calE		200 (0 (0) 03 0 001354201	100 01).				
687			0						
Вох	n certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deliv	ery
	death	sicia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown				Month	Day Year
О.	that the de ed by the detached	Phys	9 🗆 Unknown						
	an gu	by	Part II. Other significant conditions con	_	ng in the underlying cause give	n in Part I.		co use contribute to t	
Orc	w require been si should I	eted	Diabetes Mellilir	^			-		
Records,	The law cate has l	Completed	panenalis				24a. Was an autopsy performe	prior to co	opsy findings available impletion of cause of
B		e Co	25. Was case referred to medical			00 Pl (D	1 Yes 2€	No 1 ☐ Yes	2 No
Vital	Physiclen: this certific ral director,	O B	eyaminer?	ospital: 1 ☐Inpatient 2 ☐ ER	VOutpatient 3□ DOA Other	26. Place of Death		e 6 ☐Other (Specia	6.1
10	g Phy er thi	ı.	27. Manner of Death		Bb. Time of 28c. Injury Injury Work	at 28	d. Describe how		y/
jor	death. ctor: After y the funer	atlo	1 Accident 5 Pending investigation	(Mona, bay row)		es 2□No			
Division	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Rura State)	al Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys	iniam Table has before in a suite	-d dst				
	Hos 24 hc Fun etely	edicai	(Check only one)	ician: To the best of my knowle er: On the basis of examination and manner stated.	and/or investigation, in my opi	e, date and place, ar inion, death occurre	id due to the caus i at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	ro the within ro the	Me	29b. Signature and title of certifier		29c. License	number		Date signed (Month,	
			Chalake 19	serzings, 1	no Doo	56986	/	2/18/04	/
K	-16)		30. Name and address of person who con		Ba) (Type, Print)				
1	<u> </u>			erzing;	7500 Itano	ver policie	y suit	lus Gran	belt, mo
	Sta Registi	_	31. Date filed (Month, Day, Year) DEC 2 1 2004	2. Registrar's Signature					20770
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			i icasc	State of Marylan	d / Denartment o		-	_	
			1 - For Stete Registrar	Otate of Marytan	Certificate		Reg	0001	41945
	Physici	an	Decedent's Name (First, Middle, Last	Ball			2. Date of Death Month	Pay X9ar	3. Time of Death 4 1:10 PM
A STATE OF THE PARTY OF THE PAR	/Medio Examir		4a. Facility Name (If not institution, give	street and number)	4b. City. Tow	m, or Location of Death	12-1	Ac-County of Dea	
	Exami	er	benesis F	der Care	Balt	imore		Kalle	ione
	Funeral		5. Social Security Number 6. Sec		Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign
	Director		578-72-3982 1 Usual Residence of Decedent	3M 2UF 79	Yrs.		April 28		+. of Columbia
	yland yland		10a. State 486. County	10c. City	y, Town or Location				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is markad other than "natural", or Items 23a or 28e-1 show other traumatic event, the Medical Evantiner must be rectified at	by Funerai Director	MD Balti	more B	altimore	2			1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number	Di	10f. Zip Cod		10g	. Citizen of What Co	ountry?
	leath in 234	erai	11. Marital Status	12. Was Decedent Ever in U.		234 of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian
9	after o	Fun	1 Never Married 2 Married	Armed Forces? 1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	of Hispanic Origin? (S Cuban, Mexican, Puert	o Rican, etc.)	Black, Whit	e, etc.
215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates://1/2				Specify: B	lack
15	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's Usual Od (Give kind of work do life, DO NOT use re	one during most of wor	king 16	b. Kind of Business	Industry
212	filed within Hygiene. thar than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Handy 1	nan	5	16-Con-	+Ractor
	al Hygi I othar vent, I	Be C	17. Father's Name (First, Middle, Last)	٠٠		18. Mother's Nan	ne (First, Middle, Ma		
<u>ya</u>	ould be Mental larkad c	P C	Horace -	mith			ence 1		en
Maryland	12 sho h and 7 Is ma trauma		19a. Informant's Name/Relationship (7	Brother	19b. Mailing Address (St	473		ity or Town, State, 2	Zip Code)
	ss t and 2 of Health item 27 l		20a. Method of Disposition	een 206. P	lace of Disposition (Name o	f	T. ARL	c. Location - City or	Town, State
9	Pages nent of I ant: If its ary or o		1 Burial 2 Cremation 3 D	Hemovai from State	emetery, crematory or other	place)	24-04 A	Deradel	0 1/4
Baltimore	permit. Page Department o Important: If any injury or once.		21. Signatu uneral Service Licen		22. Name and Ad	ddress of Facility Pe	yton Ful	neral p	Home
<u>m</u>	82 2 2 3		Tennat &	Cohenson	2205 5	. Shirling	ton Rd.	AFL VA	22206
			23a. Part1. Enter the disease, of comp shock, or heart failure. List only	ilications that caused the death one cause on each line.	n. Do not enter the mode of	dying, such as cardiad	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		SEPSIS	•			14 Deys
	Examiner			Due to (or as a consequ	uence or):				3.50
	n ë	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):				
	ecute and trans	Examiner	Causa (Lisease or injury that initiated events resulting in death) Last	C. Due to for so a serious					
760,	ite be executed iysician and ne burial-transit	icai E		Due to (or as a consequ	dence of):				
687	~ ~ ~	edic		d				11 - 22 - 20 - 20 - 20	
Box	h cert ending	M/us	230. Was decedent pregnant	23c. If yes, outcome of pregnal	ncy I death 3 ⊟Ectopic pregna	ancy		23d. Date of del	ivery
	ires that the death cer signed by the attendir d be detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown				Month	Day Year
P.0	that the	Phy	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying cause	given in Part I	23e. Did tobac	co use contribute to	the cause of death?
Records,	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as it	d by	METASTATIO	<u> </u>		•	1 □ Yes		~/·
000	aw requir s been si 2 should l	olete	DIABE				24a. Was an		topsy findings available
I Re	The lav	Completed by Physician/Med		NTENTIE	ρ _N .		autopsy performed 1 ☐ Yes 2	death?	completion of cause of 2 \rightarrow No
Vital	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		0.1.	th (Check only one)		
of	Phys r this ral dir	- L	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inpatient 2 □ I	ER/Outpatient 3 DOA 28b. Time of 28c.		ome 5 Residence		cify)
lon	Attanding r death.	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		njury at Work? 1 □ Yes 2 □ No		injury occurred	
Division	r Attandir er death. rector: Ai	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, factory, off	ice	28f. Location (Stree City or Town, S		ral Route Number,
ā	Hospital or A 24 hours after Funaral Direc tely filled in by		4-12					, 	
	To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier TS Certifying Physics (Check only one)	ysician: To the best of my knowiner: On the basis of examinat apermanner stated.	wledge, death occurred at th tion and/or investigation, in n	e time, date and place ny opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			ense number		Date signed (Month	
•			2200	www.	Do	06176	DE DE	CEMBER	172004
D	(1) 11/		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	I Le Aire	= PAIT	4.Dr = 4	. 10 2
	Sta	te	31. Date filed (Month, Day, Year)	B2. Registrar's Signat	ture	TCh2 HAL	POMOIL	inutice K	いりくにとう
	Registr		DEC 2 1 2004	32. Registrar's Signat	Done				

			1 - For Stete Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment o <i>rtificate</i>	of Health ar of Death	nd Mental Hy	gien e () (14 41946
	Physici /Medic		1. Decedent's Name (First, Middle 2	Nie	Be	nder		2. Date of De Month	Day	3. Time of Death 2004 1236 PM
	Examin Funeral		4a. Facility Name (If not institution, giv 5. Social Security Number 6. S	Hist Hospin	(In yrs. last birthday,	GRW If Under 1 Y	wn, or Location of Park Year If Under 24 Pays Hours	MT	Mon	9. Birthplace (State or Foreig, Country)
	Director works	or	Usual Residence of Decedent 10a. State 10b. County	George's	10c. City, Town or L Univer:	ocation		April 3	3, 1927	Gastonia, NC 10d. Inside City Limits 12 Yes 2 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	i Director	10e. Street and Number 4202 Tuckerman	Street	19. 4.	10f. Zip Co	ode 207	782	10g. Citizen of USA	What Country?
920	or Ite	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 四Yes 2 N If Yes, Give Year or Dates:	ever in U.S. 13.	Was Deceden If Yes, specify		in? (Specify Yes or No Puerto Rican, etc.)	Bla	ce-American Indian, ack, White, etc. My: White
Maryland 21215-0036	"natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	(Give	dent's Usual C kind of work of DO NOT use r	done during most o retired)	of working		Business/Industry L Union #5
yland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last Frank Joseph Be				Ger	s Name <i>(First, Middl</i> e, ctrude Kale	2	
	rt.		19a. Informant's Name/Relationship (Diane E. Hicks -		4510	Albion	Road, C	or Rural Route Numbe	k, MD	20740
Baltimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special	(y)	Metropolit	matory or other an Crem	atory De	c. 21, 200	4 Alexa	
	belonit. Page Dep riment Important: Il any Injury o		21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	splic shorts that caused one cause on each lin	0137314 the death. Do not en	739 ball ter the mode o	timore A f dying, such as ca	venué, Hŷa	ittsvill	Home, P.A. Le, MD 20781 Approximate Interval Between Onset and Death
8760,	/Medical Examiner	dical Examiner	disease or condition resulting in death) Sociately list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of): consequence of): consequence of):	litus	sease			yars
.O. Box 6	requires that the death certificate een signed by the attending phys nould be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the control	2 ☐ Fetal death 3 (⊒Ectopic pregr ⊒ Other (spech				ate of delivery onth Day Year
ords, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of the perfect significant conditions	contributing to death bu	t not resulting in the t	underlying caus	se given in Part I.	23e. Did to		ntribute to the cause of death? Probably 4 □Unknown
Vital Records,	The law ate has b page 2 sl	Completed	Cerebrovascula	r diseas t cerebr	e with overscular	Pessib	le_ dent	24a. Was autor perfo	osv	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vit	Physician: this certific ral director,	: To Be	25. Was case referred to medical examiner? 174 Yes 2 □ No 27. Manner of Death	Hospital: Inpatier			Othor	of Death (Check only of Sing Home 5 Residue)		
Division of	ding n. After fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day	Yea <i>r)</i> Injury	М	Work? 1 ☐ Yes 2 ☐ No	0	Street and Numi	ber or Rural Route Number,
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 12 Certifying Plants Certifyin	nysicien: To the best of miner: On the basis of and manner sta	examination and/or in	th occurred at to	he time, date and my opinion, death	place, and due to the occurred at the time,	cause(s) and made,	anner as stated. and due to the cause(s)
•	To the within 2 To the comple	Me	29b. Signature and title of certifier	ion MD		29c. L	2030	12	29d. Date signe Vecem	bor 20, 2004
	9		Norten Elson	completed cause of de	000 (arr	ell Av	e. Tak	koma Par	k MI	20912
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 2&3 Per Phy.gc, 12/23/0 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dayl 3 Year Month **Physician** BLAN CHARD LINDA .2004 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner CLINTON MD PRINCE MARYLAND SOUTHERD HOSPITAL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 56 218-52-8238 Director April 26,1948 Wash. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State itam 27 la markad othar than "natural", or Itams 23a or 28a-f ahow other traumatic evant, the Ne Ital Exunt are must be multiped at Brandywine MD Prince George's 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 10505 Cedarville Road, Lot 9-13 USA 20613 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2/☐ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene (important: if itam 27 la marked other than any injury or other traumatin avenue. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Windsor Blanchard Lottie Mae Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Blanchard/sister-in-law 7990 Terry Drive Port Tobacco, MD 20677 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Cedar Hill Cemetery 12/17/2004 Suitland, MD 21. Signature of Funeral Service Licensia 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave. Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carclio-De thitatery Privaician /Medical Due to (or as a gensequence of) Examiner hellmonal Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medlcal as the t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal deal
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ End 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 Yes 21010 within 24 hours after death.

7 the Funaral Director: After this certifics completely filled in by the funeral director. To the Hospital or Attanding Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Latient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ N P 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 00061652 MD pleted cause of death (Item 23a) (Type, Print) 30. Name person who co address of PILCATAWAY RD 9131 D12 YM SUITE 750 31. Date filed (Month, Day, Year)
DEC 2 2 2004 32. Registrar's Signati State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. Decedent's Name (First, Middle, Last) 2. Date of Death December 15, **Physician** Karl Frederick Barth, Sr. 10:00 a M 2004 /Medical 4a. Facility Name (If not institution, give street and number)
8941 Limerick Lane 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Owings Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Apr 8, 1945 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1XM 2□F 59 220-42-3967 Director Washington, Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygene.

ans. If Heau 27 Is marked other than "natural", or items 23a or 28a-1 show ans. If item 27 Is marked other than "natural", or other treumatic event, in the include Examiner outs the multiple at MD1 ☐ Yes 2 No Calvert Director Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8941 Limerick Lane 20736 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer U.S. Capitol Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Erwin E. Barth Cora Fritter 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa Barth (wife) 8941 Limerick Lane Owin's MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 5 Other (Specify) Southern Mem. Grdns. 2004 4 Donation Dunkirk, MD 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licenses Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) izyean Dancreate Physician Cano /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) _ detached 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by abete 1 Yes 2 No 3 Probably 4 Onknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 NO Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 76 Certification: To 27. Mann of Death 1 atural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Eliano, mo 1747313 12/16/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15+1 Joyce Owens, MD 10845 Town Center Blvd Ste 203 Dunkirk, MD 20754 31. Date filed (Month, Day, Year) 32. Registras Signature State 2004 Elawa! Registrar

			. FOI	artment of Health and Menta <i>rtificate of Death</i>	Hygiene
			Decedent's Name (First, Middle, Last)	2. Date Mor	e of Death 3. Time of Death
	Physici /Medic		Everett C. Beach		ember 13 2004 5PM M
	Examin	er	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital	4b. City, Town, or Location of Death Leonardtown	4c. County of Death St. Mary's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Security Number 6. Sex 9. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Sex 9. Security Number 6. Secur	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. July	e of Birth Ph. Day (State or Foreign 10 24 (State or Foreign 9. Birthplace (State or Foreign 9. Birthplace (State or Foreign 9. Birthplace (State or Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland St. Mary's Charlotte		10d. Inside City Limits 1 ☐ Yes ※∑ No
	r 28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a o	al D	29449 Charlotte Hall Road	20622	United States
36	be filed within 72 hours after death with the Maryland nat Hygiene. od other than "natural", or items 23a or 28a-1 show event, the Modical Examinar must be notified at	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Xes 2 □ No	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 ☐ No Specify:	s or No- ptc.) 14. Race - American Indian, Black, White, etc. Specify hite
Baltimore, Maryland 21215-0036	thin 72 hou e. an "natura Medical E	Completed	(Specify only highest grade completed) (Give life. Slementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
7	filed with Hygiene. other thar			al Worker	US Government
yland	2 should be filed and Mental Hygi Is marked other raumatic event, II	To Be	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name (First, Pearl Unkr	Nown
Mar	is 1 and 2 sho of Health and item 27 is my other traumy		Brenda Lee Burg - daughter 109 100 100 100 100 100 100 100 100 100	ng Address (Street and Number or Rural Route S. Luther Lane Co]	Number, City or Town, State, Zip Code) Lumbia PA 17512
more	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ex 2005.		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposemetery, cremetery, cremetery, cremetery.	osition (Name of matory or other place) Dec 18 2004 coln Cemetery	20c. Location - City or Town, State Eladensburg Maryland
Balti	permit. Departn Imports any inju		12000		h Funeral Home rt Republic Maryland 20676
	Physician /Medical Examiner		23a. Parl . Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. subarachnoid blee Due to (or as a consequence of): Sequentially list conditions, b. cerebro vascular	đ	Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). C. Due to (or as a consequence of):		
.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	by Physician/Mec		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
<u>α</u>	luires that n signed build be deta	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the unposition	nderlying cause given in Part I. 238	Did tobacco use contribute to the cause of death? □ Yes 2 □ No 3 □ Probably 4 □ Onknown
Records,	The law requir sate has been si page 2 should	Completed			a. Was an autopsy performed? yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?
Viital	ysician: The is certificate director, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check	
	Phys this al di	2	1 ☐ Tes 2 ☐ No		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
Division of	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Local	ation (Street and Number or Rural Route Number, or Town, State)
	To the Hospital or within 24 hours affe To the Funeral Dirt completely filled in I	Medical C	29a. Certifler (Check only one) 1 Certiflying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due vestigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
ł			- Andary woo	1)29821	17/13/04
ı	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	·	
l'	Sta	to	James I. Damalouji, M.D. Leonar 31. Date filed (Month, Day, Year) 32. Registra's Signature	dtown, Maryland	
	Sta Registi	_	James I. Damalouji, M.D. Leonar 31. Date filed (Month, Day, Year) DEC 1 6 2004 Mature	Sparker	

			For State Registrar		Maryland /	Depa		of H	ealth a		lental Hy	_	04	41950
	Dhuaisi		1. Decedent's Name (First, Middle, La								2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Nellie May B	oucher							Dec 11			1530 ™
	Examin		4a. Facility Name (If not institution, gi				4b. City, To						ty of Death	
			Calvert Memo				Prince					Calve	_	
П	Funeral Director		577 05 7111	Sex 7. 1 □ M 2,27 F	Age (In yrs. last b	Yrs.	If Under 1 Months	Days	If Under: Hours		8. Date of Bir OCL 2	1 th 9 th 4 th	9. Birth	place (State or Foreign Mington DC
Maryland	fahow fied at	tor	Usual Residence of Decedent 10a. State Maryland Calver	t	10c. City, Too SO	wn or Loc								10d. Inside City Limits 1 □ Yes 2 No
with the	3e or 28e	i Direc	10e. Street and Number 11740 Circle Apt	. 115	l		10f. Zip C					10g. Citizen of United		
Ind 21215-0036 he filed within 72 hours after death with the Maryland	popular in ago of Health and Mental Hygiene. Importantial of Health and Mental Hygiene. Importantial if item 27 Is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic avant, the Medical Eur. institutative nullified of once.	y Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decede Armed Force 1 ☐ Yes 2% If Yes, Give	s? ≧No		/as Deceder Yes, specifi		spanic Origin, Mexican	gin? (Spo	ecify Yes or No Rican, etc.)		ce - Ameri ack, White,	
Maryland 21215-0036	"natural" edical Ex	leted by	3, Widowed 4 □ Divorced 15. Decedent's E (Specify only highest g.			a Decede	ent's Usual kind of work O NOT use	Occupa	tion uring most	of work	ing	16b. Kind of E		
1212.	Tygiene. thar than nt, I've M	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las	College (1-4d	or 5+) A	udit						US GO		ent
arylanc should be f	Mental Parked of	To Be	Harry Woodburn S	wann					Kath	erin	e E. Ka	archer		
, Mar	ealth and n 27 la m		19a. Informant's Name/Relationship Allen Bender– per	_(Турв, Print) sonal rep	resent 2	411 P	imernel	Dr.	Wald	rf M	20603	er, City or Town		
Baltimore,	populment of Health amportent: If item 27 is any injury or other tra		20a. Method of Disposition 1'∰Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Spec		20b. Place cement Cedar I	пт (- IECEL	- <u>y</u>	;			20c. Location Suitland	-	
Balt	Departr Import any inj		21. Signature of Funeral Service Lice	nsee							sch Funer Republi	al Home c Marylan	nđ 206	76
	hysician	112	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Per:	pheral	Vas	the mode	of dying	dise	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical xaminer	er		1	as a consequence	e of): (Gar e of):	-t t	Sail	urc					years
760,	al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequence		luti	~						years
	physician	icai	(d. M 125	A infer	wit.	of	nu	n-lu	ulin	y alar	1 les		murthe
O. Box	y th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 ☐ Fetal deat t at time of death		Ectopic preg Other (spec						ate of delive onth	ery Day Year
	n signed build be deta	d by P	Part II. Other significent conditions (Wan, C Of Ste		but not resulting		derlying cau	use give	n in Part I.			obacco use con Yes 2□No	/	he cause of death?
Vital Records,	certificate has been s lirector, page 2 should	ompiet	Hypertensin	¥	. 7.					_		rmed?	prior to co death?	ppsy findings available mpletion of cause of
	(0 ===	0	25. Was case referred to medical	104	74 0				26. Place	of Death	1 ☐ Yes		1 Yes	213 140
of Vita	is cer	To B	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	atient 2 ER/C	Dutpatient	3□ DOA	Othe	r			dence 6 □Ot	her (Specit	(v)
on of	After this		27. Mann i Death 1 atural 5 Pending investigate		njury 28b. <i>Day Year)</i>	. Time of Injury	28c	c. Injury Work	at			now injury occu		
Division alor Attanding	o i te	Certification:	2 Accident 3 Suicide 6 Could not determined	28e. Place of	Injury - At home, t etc. (Specify)	farm, stre					28f. Location (3 City or Tox		ber or Rura	al Route Number,
Diving Hospital or	within 24 hours a To the Funeral C completely filled	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the bearinger: On the basis	s of examination a	ge, death and/or inve	occurred at estigation, in	the time	e, date and inion, deat	d place, h occurr	and due to the ed at the time,	cause(s) and m date and place,	anner as s and due to	tated. o the cause(s)
5	To the comp	W	7 1 1	- SPITACI			0		number	0		29d. Date signe	ed (Month,	Dey, Year)
	0		30. Name and addless of person who Addes b Jahran 31. Date filed (Month, Day, Yeer)	100	HOSP ITAL	- R	Print)	PV			ederica	, ms	20	678
	, Sta Registr			L 4 2004	Signature	H.	Spar	les	-					

			For State Registrar	State of Mar		artment o				giene	4 41951	
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time of Death	_
	Physici /Medic		Thomas	Anthony	Brzosto	owski			Decembe	- · ·	7:00 A. ^M	4
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tov	vn, or Locet	tion of Death		4c. County of		
		37	Suburban Hospital				nesda	ada O4 Um		Montg		
п	Funeral		5. Social Security Number 6. Sex	M 2 F	(In yrs. last birthday) Yrs.	If Under 1 Y Months D	ays Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)	n
	Director		191-32-1738 Usual Residence of Decedent		60 Yrs.				July 30	,1944	PA.	
	yland		10a. State 10b. County	1	10c. City, Town or Lo	cation					10d. Inside City Limits	,
	e-fsl	ctor	Maryland Montgomer	·y	German	town					1 ☐ Yes 2 X No)
	or 28	Directo	10e. Street and Number			10f. Zip Co	de			10g. Citizen of Wh	nat Country?	
	ath w 23e		11404 Seneca Fores	t Circle			0876			USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show empiricity or other treumetic event. The Medical Examinar must be notified at an once.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	 Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 		Was Decedent f Yes, specify 1 ☐ Yes 2X		c Origin? (Spaxican, Puerto ecify:	ecify Yes or No- Rican, etc.)	14. Race- Black, Specify:	- American Indian, White, etc.	
21215-0036	2 hou		15. Decedent's Educ	ation	16a. Deced	dent's Usual O	ccupation			16b. Kind of Busi	White iness/Industry	_
215	hin 72	Completed	(Specify only highest grade	completed) College (1-4or 5+)	life, i	kind of work d DO NOT use re	lone during etired)	most of work	ing		,	
21	giene grene er the	E O	Elementary, desertating (6 12)	5+		Analys	t			Aerospac	e Company	
nd	al Hy d othe	Be (17. Father's Name (First, Middle, Last)				18. M	lother's Name	e (First, Middle,	Maiden Sumame))	
yla	Ment Ment arkec	2	Anthony	Brzostow	ski				France	s Slu	pski	_
Maryland	i 2 should be filed within 7 h and Mental Hygiene. F is marked other then " freumetic event, the Mad		19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (St	reet and Nu	umber or Rura	al Route Numbe	r, City or Town, St	tate, Zip Code)	
	l and lealth m 27 her tr		Sharon L. Brzostows	ki/Wife	11404 20b. Place of Dispo				rcle, Go		n, MD. 20876	_
Baltimore,	T of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crer	sition (Name o natory or other	r place)				ity or Town, State	
Ë	The Parising		*4 □ Donation 5 □ Other (Specify)		All Souls						wn, Maryland	
Bal	permit. Par Department Importent: eny injury		21. Signature of Funeral Service License)/ () ex	/ 4 V/ 1 . 1000					eral Home		
			23a Pul Enter the disease or compli	tions that caused th	ne death. Do not ent						g, MD. 20877 Approximate	_
	Physician /Medical Examiner		23a. PM1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	METO	3777	UNG	CAN		or respiratory ar		Interval Between Onset and Death	
		iner	Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							
, 0,	sate be executed only sicien and the burial-transit	i Examine	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
8760,	physic the b	dical	d			_						
.O. Box 6	death certifi e attending ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of 1 Live birth 2 4 Pregnant at tir	Fetal death 3	Ectopic pregn Other (specif				23d. Date of Month		
Δ.	es that the de igned by the be detached	/ Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause	e given in P	Part I.	23e. Did to	bacco use contrib	ute to the cause of death?	
Sp	uires I sign Id be	d b	PULMONARY	EMBOU!	SM				to	es 2□No 3	☐ Probably 4 ☐Unknown	ı
Records,	The law requires that the cate has been signed by the page 2 should be detache	Completed							24a. Was a autop perfor	sy prid med? dea	ere autopsy findings available or to completion of cause of ath?	,
Vital	iclen: Th certificate rector, pag		25. Was case referred to medical				20 0	Place of Dooth			Yes 2 No	
⋚	Physiclen: this certific ral director,	o Be	examiner?	ospital:	2 ER/Outpatien	t 3 DOA			n_(Check only o	ence 6 Other	(Specify)	
Division of	ding After fune	\vdash	27. Manner of Death 1	28a. Date of Injury (Month, Day)		28c.	Injury at Work?			ow injury occurred		
Divis	or At Ifter of Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	et, factory, of	fice		28f. Location (S City or Tow		or Rural Route Number,	
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medicel Exeminates	icien: To the best of er: On the basis of e and manner state	xamination and/or inv	occurred at the	ne time, dat my opinion,	e and place, death occurr	and due to the c ed at the time, c	ause(s) and mann date and place, and	ner as stated. d due to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier				cense numb		1	29d. Date signed (- ,	
}	70		/ Wich fun	m		023	3308			DCC. 14,	2009	
	·~		30. Name and address of person who con VICTOR M. PRIECO, A	npleted cause of dea	ROCKLEN	Print) 16E DA	7. H	4100	BETHE	802, NO	120817	
	Sta Registr	_	31. Date filed (<i>Month, Day, Year</i>) DEC 16 200	32. Registrar'	s Signature	Spar	Kal				-	

			1 - State Registrar	ate of Maryla		artment of H			Hygien	2001.	41952
П		• 🐙	Decedent's Name (First, Middle, Last)					2. Date	of Death		3. Time of Death
	Physici /Medic		STEPHEN	LEVI BRO	WN			Mon D1	th Da EC 12	2004	4:47 A M
	Examin		4a. Fecility Name (If not institution, give stree	and number)		4b. City, Town, or	Location of	of Death	40	c. County of Dea	ith
			NATIONAL NAVAL ME				IESDA			MONTGO	
	Funeral		5. Social Security Number 6. Sex	20 5	rs. last birthday) Yrs.	Months Days	tf Under :	Min. (Mor	of Birth th, Day, Year	9. Bit	thplace (State or Foreign ountry)
	Director		115-68-3814 Usual Residence of Decedent	20	0 115			APRI	L 12,1	984 N	EW YORK
	show		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
	e-f st	ctor	NY SUFFOLK			MEDF	ORD				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	ountry?
	ath w		90 WILSON AVE.				11763			U.S.A	
	ltems	Funeral	A	/as Decedent Ever in med Forces?		Was Decedent of Hi If Yes, specify Cuba	ispanic Orio n, Mexican	gin? (Specify Yes i, Puerto Rican, e	or No-	14. Race - Am Black, Whi	
36	ours after death with the Maryla ral', or Items 23a or 28e-f sho Examiner must be notified at	by F	1 Never Married 2 Married 1 3 Widowed 4 Divorced		02-	1 ☐ Yes 2 🔀 No	Specify:			Specify:	BLACK
21215-0036	thin 72 hours after death with the Maryland e. an "nafural", or Items 23e or 28e-1 show Medical Examiner ment be notified at	ted	15. Decedent's Educatio	2 (dent's Usuat Occupa			16b. I	Kind of Business	
215	E . E .	Completed	(Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	(Give	kind of work done of DO NOT use retired,	during most ()	t of working			,
2	¥ 6 € 5	Соп	12			U.S. MAI	RINE			DEFENSE	
Maryland	0 = 0 \$	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name (First, M		,	
3	2 should be and Mental Is marked eumatic ev	ဥ	STEVEN N.	BROWN	405 44-18			CORNELI			
Mai	d 2 sh th and 7 Is n treun		19a. Informant's Name/Relationship (Type, F	own/Mothel	1	ng Address (Street a					Zip Code)
	1 an Heali Iem 2		CORNELIA ANN BR	· · · · · · · · · · · · · · · · · · ·	. Place of Dispo	WILSON A		MEDFORD, Date		.ocation - City or	Town, State
no	it. Pages 1 and 2 should be treent of Heatth and Menta reent: If item 27 Is marked njury or other treumatic ento.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)			natory`or other place N_NAT [†] L (12 21 20		•	
Baltimore,	permit. F Departme Importer any injur		21. Signature of Funeral Service Licensee	7 -	22	. Name and Addres	s of Facility	у		LVERTON	
m	Per Per Per Per Per Per Per Per Per Per		10-20- Chame	when MOO	0091 CI	HAMBERS FI 301 CLEVE	UNERA LAND	L HOME & AVE. RT	CREMA VERDAL	TORIUM,	P.A. 20737
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the deuse on each line.							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	METAST	ATTC GE	RM CELL C	ANCER				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a cons							
	_xanimici	<u>.</u>	Sequentially list conditions, b	Due to (or as a cons	oguenae of/:						
	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D 40 10 (01 43 4 CO113	04401100 017.						
<u>_</u>	execu n and ial-tra	Examiner	that initiated events c resulting in death) Last	Due to (or as a cons	equence of):						
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dical	d								
9	ntifica ng ph as th	Medi	tF FEMALE:								1000
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	yes, outcome of preg □Live birth 2 □ Fe	etal death 3	Ectopic pregnancy			1	23d. Date of de Month	livery Day Year
0.	it the dea by the a tached fo	/sic	1 Type 2 TNo	□Pregnant at time o □Unknown	fdeath 5	Other (specify)				World	Day 10a
<u>α</u>	that the		Part II. Other significant conditions contribu	ting to death but not r	esulting in the u	nderlvina cause give	en in Part I.	23e	Did tobacco	use contribute to	the cause of death?
Records,	es pe	d by							1 ☐ Yes 2	XINo 3□P	robably 4 Unknown
S	w requir been si should	Completed						24a	Wasan	24b. Were a	utopsy findings available
Re	The law ate has b page 2 st	шс							autopsy performed?	prior to	completion of cause of
Vital		O	25. Was case referred to medical				26. Place	of Death (Check) IL Yes	: 2□ No
Į.	di ib	To B	examiner? 1 ☐ Yes 2 XNo Hospi	al: 1 🔀 Inpatient 2	☐ ER/Outpatier	t 3 DOA Othe	10	rsing Home 5		6 ☐Other (Spe	cify)
n of			27. Manner of Death 1 XNatural 5 Pending	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Des	cribe how inju	iry occurred	
Sio	Attending r death. ector: After oy the fune	catio	2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆 Y	Yes 2□N				
Division	or Diric	Certification:	4 Homicide determined 28	e. Place of tnjury - At building, etc. (Spe	t home, farm, str c <i>ify)</i>	eet, factory, office		28f. Loca City	tion (Street al or Town, State	nd Number or Ri e)	ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 X Certifying Physicia	1: To the best of my k	nowledge death	occurred at the tim	e date an	d place, and due	to the cause/o	and manner or	stated
	24 h	edical	(Check only 2 Medical Examiner:	On the basis of exami	ination and/or in	vestigation, in my op	pinion, deat	th occurred at the	time, date an	d place, and due	to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. License	number		29d. Da	ate signed (Mont	h, Day, Year)
) ,	^		1 XX	DO		RES-0	00		12	, 13, 2	2004
l	41		30. Name and address of person who comple		tem 23a) (Type,			L NAVAL	MEDICA	L CENTE	
				4C USNR		BE'	THESD	A MD 208	89-560	0	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 16 2004	32. Registrar's Sig		Sparks					
C3			DEO 10 2007	1		//					

			1 - For State Registrar	State of Ma	ryland	/ Depa	artmen rtificate	t of H e <i>of L</i>	ealth a D <i>eath</i>	and M		giene (004	41953
1	Physici	an	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		John A	Beac	h,	Jr.					13	15	04	1600 M
	Examir	ier	4a. Facility Name (If not institution, give	0	1.				Location o			4c. Co	unty of Dea	th
			University of		lanc				mor			Ba1	timor	e
	Funeral		5. Social Security Number 6. S	ex 7. Age CM 2□F	(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under:	Min.	8. Date of Birt May 19	h V. Year Q 23	9. Bir	thplace (State or Foreign ountry) yland
	Director		212-19-1530 Usual Residence of Decedent		21	113.					may 19,	, 1903	Mai	yrand
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Many f sh	ţ	Maryland St. Mar	ry's		Lexi	ngton	Par	k					1 ☐ Yes 2 ☐ No
	r 28e	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Co	ountry?
	h wit		46115 Nancy Ct.					2	0653			US	A	
	dead	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.		erican Indian,
9	or Ite	F	1 X Never Married 2 ☐ Married	1 XYes 2 No	0	- 1	1 ⊡ Yes 2			, Puerto I	Hican, etc.)		Black, Whit	te, etc. White
8	72 hours after death with the Marylan neturel', or Items 23a or 28e-f show digal Examinational by critified at	d by	3 Widowed 4 Divorced	Year or Dates:			10163 2	26.1110	эрөспу.			Sp	ecify:	
21215-0036	s within 72 hours after death with the Maryland liene. I them "neturel", or terms 23a or 28e-1 show I're Mardical Examinar i mat be trafflied at	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usua kind of wor	k done a	urina most	of workii	ng	16b. Kind	of Business	/Industry
12	within ene. than	E E	Elementary/Secondary (0-12)	Coilege (1-4or 5+	-)		DO NOT us	·				TT 6	37	
2	77 77 2		17. Father's Name (First, Middle, Last)				Seama	n	10 Matha	do Nome	(Cinc. & Sindella		. Nav	У
anc	d fall o	Be							io. Motrie		(First, Middle, ny Ann)			
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other treumatic ev	ို	John Alexander 19a. Informant's Name/Relationship (7)			10b Mailie	Address	/Street o	and Alessania		l Route Numbe			7 0 11
Ma	o,		Kathy Beach/mothe			461	15 Na	ncv	na Numbe Ct	Lexi	ington I	r, City or To	MD 20	21p Gode) 1 653
	s 1 and 2 if Health a item 27 is other tre		20a. Method of Disposition		20b. Plac		sition (Nam		-		ate			Town, State
Baltimore,			1 ABurial 2 ☐ Cremation 3 ☐		cem	netery, crer	natory or ot	ther place		T	ec.22.	Zoc. cocati	on · Oity of	Town, State
Ħ			 4 □ Donation 5 □ Other (Specify 21. Signat@e of Funeral Service Licen 		Arlı	ngton	Nati	onal	ceme	Rei	2004 1	Fahot	ers.	Virginia
Ba	permit. Departr Importe eny init		X Grand RA	CI										, MD 20622
			23a. Part1. Enter the disease, or comp	plications that caused t	he death								I	
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line).		or the mode	o or dyning	, such as t	Jai Glac O	i iespiiatory ari	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Intra			he	MO	rcho	1age				
	Examiner			Due to (or as a		, .								
		Ē	Sequentially list conditions,	b. Centra	CONTSHOUR	UVOU	5 54	Stem	101	Kect	2001	_		
	icate be executed physician and s the burial-transit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				atra w	201	CIA.		-14:00 0	-00+		
~	n and	Exa	resulting in death) Last	c. Ventricu	consequer	nce of):	111014	2001		1817	piaca	Man		
8760,	death certificate be executed e attending physician and id for use as the burial-transi	dicall		d			(1	11 0	12				
89	tifficat ng phy as the	edle		u		C	ERTIFICATIO	N APPRO	VED BY	DICAL EX	AMINER			
Вох	eath certif attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of				0				23d.	Date of deli	iverv
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti			Ectopic pre Other (spe						Month	Day Year
0	the che	hys	9 Unknown	9□ Unknown										
σ,	requires that een signed b hould be deta	by P	Part II. Other significant conditions of	entributing to death but	not resultin	ng in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	pacco use c	ontribute to	the cause of death?
ğ	w require been sig should b	edk									1 □ Ye	es 2⊠No	3 ☐ Pro	obably 4 Dunknown
Records,	s bee	Completed									24a. Was a	n 24	b. Were au	topsy findings available
Ä	The law cate has b page 2 sl	E									autops	ned2	prior to death?	completion of cause of
Vital		Be C	25. Was case referred to medical						26 Place	of Death	(Check only on	No No	1 🗆 Yes	2 No
>	ys diis	To B	examiner?1	Hospital:	2 🗆 ER	VOutpatien:	3 DO/	Other			ne 5 ☐ Reside		Other (Sner	260
οl	g Ph ter th neral	2	27. Manner of Death	28a. Date of Injury (Month, Day)	28	Bb. Time of Injury		lc. Injury Work			8d. Describe ho			any/
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Ξ	er de recto	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	v - At home			office		2	8f. Location (St City or Town	reet and Nu	mber or Ru	ral Route Number,
	rs aft el Di	Cer		,	one					0	HAVLES C		GM	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only 2 Medical Exam	sician: To the best of	my knowle	dge, death	occurred a	t the time	, date and	nlace a	nd due to the co	uce(c) and	manner ac	stated.
	the F in 24 the F iplete	ledi		iner: On the basis of e and manner state	ed.	and or inv	estigation,	п пу орг	nion, death	occurre	u at the time, da	ate and plac	e, and due	to the cause(s)
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	200		30. Name and address of person who d				Print)	and	mp (Rei	SS-FIC	17	MD	
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Description of the property of					For 1 = State Registrar	State	of Maryla	nd / Depa		of Health	and M	lental Hygi	-	4	419	154
DAVID EDWARD BROWN III. Special property of constructions agree what whether the control of the			Dhusisi			le, Last)						2. Date of Deat	1	Vear	3. Time	of Death
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215-38-38-38 Go Do Tambridge of Devoting Country (1997) Mash. DC. Count		н			5. Social Security Number	6. Sex	7. Age (In yrs	**	If Under 1 Y	ear If Unc	er 24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State	or Foreign
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Physician Medical Examiner Ph	()	- 0	ltems	nne		Armed F	Forces?	U.S. 13.	Was Decedent f Yes, specify (of Hispanic Cuban, Mexi	Origin? (Spe can, Puerto	ecify Yes or No- Rican, etc.)				
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Physician Medical Examiner Ph	7 8	Me S	and 2	1	DIANA RAWLINGS	BROWN- W	IFE	1670	00 Mt.	Calver						772
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Physicial Examiner Wedles Examiner Figure 19 Physician Examiner Fi			1927		23a. Part1. Fiter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the dea							7150	Approxima Interval Be	etween
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Sequentially list conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Dither significant conditions contributing to death but not resulting in the underlying cause given in Part I.								- 4	2						6 m	onles
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State St	1, -		urs aft arel Di		TOO CONTINUE AND CONTINUE											
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			A 1,81	epartment of Health and M Dertificate of Death		1002ene	41955
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Mary Frances Barrett		December	11, 2004	4:25 ам
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			Manor Care-Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs. last birth)	Bethesda day) If Under 1 Year If Under 24 Hrs.	0.0000000000000000000000000000000000000	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 1 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	ear) Cou	place (State or Foreign intry)
			Usual Residence of Decedent		July 30,	1928 Was	hington, DC
	arylan show	_	10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
	Be-f	Directo	Maryland Montgomery Bethes				1 ☐ Yes 2 ☑ No
	with the		10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	untry?
	leath	Funeral	6530 Democracy Blvd. 11. Marital Status 12. Was Decedent Ever in U.S.	20817 13. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	USA 14. Race - Amer	ican Indian
0	r ten	Fun	1 TNever Married 2 Married 1 TYes 2 TNo	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 	Rican, etc.)	Black, White	, etc.
9500-6121	72 hours after death with the Maryland "netural", or ltems 23a or 28e-f show after Examiner met be mylling at	i by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		SpecifyWhit	.e
ည်	i within 72 ho jiana. r than "netui IDV Modical	Completed	(Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of working	10	b. Kind of Business/Ir	
	withir	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)		overnment/ civate Sec	
7	9 X 9 +	e Co	5+ S	Security Analysis 18. Mother's Name			urities
ä	ld be ental ked o	To Be	Russell Francis Barrett			,	
Maryland 2	permit. Pages 1 and 2 should be fill Department of Health and Mental H Importent: If Item 27 Is marked out any Injury or other traumatic even once.	-		Mailing Address (Street and Number or Rura	Baldenbur Route Number, C		p Code)
Ž	and 2 valth a 127 ls		Kathryn Pheobus/ Niece 106	28 Eastwood Avenue,	Silver S	Specimen MD	20901
galtimore,	of He		20a. Method of Disposition 20b. Place 20b. Place	crematory or other place) Decemi	oer 17	c. ocation - City or T	own, State
Ĕ	Pag ent: I		Pount (Specific	Olivet etery 200	14	shington.	DC
<u>a</u>	ermit. Separt riport ny Inj nce.		21. Signature of Funeral Service Licensee	Francis J. Collins I	Tuneral H	Home Inc	
	707 8 Q		23a. Cart1. Enter the disease, or complications that caused the death. Do no	500 University Blvd			
			shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition a Ereast Cancer				
	Examiner		Due to (or as a consequence of)				
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ď,	e exe	EX	resulting in death) Last Due to (or as a consequence of)				
8/PU	certificate be executed ding physician and see as the burial-transit	dical	d				
٥ ×	leath certifica attending ph	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
X Q Q	atter for L	iclan/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
j.	the d y the ached	Physi	1 Yes 2 No 9 Unknown 9 Unknown				
ς, T	w requires that the debeen signed by the should be detached	by PI	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
	en sig				1 Tes	2 ☐ No 3 ☐ Prob	bably 4 XUnknown
ecord	g S C	ompleted			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
<u>r</u>	Th ate pag	Соп			performed 1 ☐ Yes 2 🔀	1? death?	
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death			
0	shys this al dia	<u>2</u>	1 Tes 22 No 1 Inpatient 2 EH/Outpa		e 5 Residence 8d. Describe how i	6 Other (Special	(y)
0	el or Attending F s after death. I Director: After d in by the funera	ertification;	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 k Natural 5 Pending (Month, Day Year)		od. Describe NOW I	illary occurred	
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5	s afte	Cert	4 Homicide determined building, etc. (Specify)		City or Town, S	tate)	
	hour hour unere	edical (29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/c	leath occurred at the time, date and place, a	nd due to the cause	e(s) and manner as s	stated.
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in birectors.		and manner stated.				
	To To	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, ecember 13	-
	3		fund mul	D35579		COCHIDET I	J, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Ty Susan J. Miller, M.D. 6844 Tu:	•	theeds *	WD 20016	
				rerrace, be	chesua, I	מדסחק חד	
	Sta	te	31. Date filed (Month, Day, Year) DEC 1 4 2004	Spark			

			1 - For State Registrar	State o	f Maryla	nd / Depa	artmen <i>rtificati</i>					giene	004	4	956
ì	Physici	ian	Decedent's Name (First, Middle,	,	2526						2. Date of Dea	ath Day	Year		ne of Death
	/Medi Examir		PHILIP . 4a. Facility Name (If not institution,	JOEL give street and nui	BERG mber)		4b. City.	Town, or	Location of		DECEMB		2004 County of Deat		:01 A ^M
			11412 DORCHESTE	R LANE				OCKV:					ONTGOME		
	Funeral Director		5. Social Security Number 213-46-9965 Usual Residence of Decedent	5. Sex 157 M 2□ F		s. last birthday) 60 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	B. Date of Birt (Month, Day EC • 28	h y, Ye <i>ar)</i> • 19	Co	untry)	N, DC
	yland		10a. State 10b. County		10c. 0	City, Town or Lo	cation							10d. Insid	e City Limits
	Ba-f sl	ctor	MARYLAND MONTGOM	IERY	ROC	KVILLE								1)(1)	Yes 2□No
	with the	Dire	10e. Street and Number				10f. Zip					10g. Citiz	zen of What Co	untry?	
	death	nera	11412 DORCHESTER 11. Marital Status	12. Was Dece		U.S. 13.	Nas Deced	208 ent of Hi		gin? (Speci	ify Yes or No-	1	U.S.A.	rican Indiar	١,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injuxed other traumatic event, Its M. dical Examinat must be natified at once.	by Funeral Director	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 ∑ No ∕e	1	f Yes, spec 1 ☐ Yes 2		Specify:	i, Puerto Ri	ican, etc.)		Black, White Specify:		
5-0	n 72 h "natu	Completed	15. Decedent's (Specify only highest			16a. Deced	kind of wor.	k done d	urina most	t of working	,	16b. Kin	nd of Business/I		
212	iene r than	omp	Elementary/Secondary (0-12)	College (1	I-4or 5+)	CERTIF	70 NOT us TED P			COUNT	ANT	۸۵۵۵۱	UNTING		
nd	al Hyg	BeC	17. Father's Name (First, Middle, La	st)		,0221222	<u> </u>				First, Middle,				
Maryland	Ment Marke Marke Marke	2	MAURICE	BER	G				ROSE				BINSKI		
<u>a</u>	od 2 st Ith and 27 is n traun		19a. Informant's Name/Relationship SANDRA W. BERG/W										Town, State, Z		
J.	ss 1 ar		20a. Method of Disposition		20b.	Place of Disposemetery, cren	sition (Nam	e of		ANE, I	ROCKVII		MD 2085 ation - City or T)
altimore,	Page Iment		1 X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe	cify)		NG DAVI	-		´	12/09	/2004 1	FALLS	S CHURC	H, VI	RGINIA
Bal	Departition Depart		21. Signature of Funeral Service Lic	State	emy	DA 11	NZANS 70 RC	ŘÝ–Č CKVI	OLDB LLE	ERG M	EMORIA ROCKV	L CHA	APELS.	INC. 0852	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cally one cause on e	aused he dea ach libe.	ath. Do not ente	er the mode	of dying	, such as	cardiac or r	espiratory arr	est,		Approxir Interval I	Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		MA MULT	IFORM	IE						9 MON	nd Death
	Examiner		Convertingly that you distance	Due to (or as a conse	quence or):									
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enlarge transport (Cause (Disease or injury)	Due to (or as a conse	quence of):									
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of);									
8760,	physiciar physiciar the buri	dical		d.											
89 X	ertifica ling ph e as th	Med	IF FEMALE:												
	that the death certificated by the attending I detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		irth 2 ☐ Fet ant at time of	al death 3 🗌	Ectopic pre Other (spe					23	d. Date of deliv Month	ery Day	Year
2	requires that the	by Ph	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the un	derlying car	use giver	in Part I.		23e. Did tob	pacco use	e contribute to t	he cause o	of death?
ecords,	w require been sig should b										1 🗆 Ye	s 2 🗆	No 3 ☐ Prot	bably 4	Unknown
Hec	The law ate has t page 2 s	Completed									24a. Was a autops perforn 1 \(\text{Yes} \) 2	v	24b. Were auto prior to co death? 1 \(\sum \) Yes	impletion o	s available cause of
VITal	ician certifii rector,	Be	25. Was case referred to medical examiner?	Hospital:							hack only on	e)			
	g Phys er this eral di	n: To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date o	f Injury	ER/Outpatient 28b. Time of		 c. Injury a 	at .		5 Aeside		Other (Specif	(y)	
loi e	Attending F r death. ector: Atter by the funera	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati	on	n, Day Year)	Injury	М	Work?	s 2 🗆 N						
_	ital or Attend rs after death al Director: /	Certification:	3 □ Suicide 6 □ Could not 4 □ Homicide determine	d 286. Place of buildin	ig, etc. (Speci						City or Town	, State)	Number or Aura		mber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier 1 X Certifying F (Check only one) 2 ☐ Medical Exa	Physician: To the laminer: On the baand manner	SIS OF BAGIIIII	owledge, death ation and/or inve	occurred at estigation, in	the time n my opir	, date and nion, death	place, and occurred	due to the ca at the time, da	use(s) an ate and pl	nd manner as s lace, and due to	tated. the cause)(s)
	To To	Σ	29b. Signature and title of certifier	4 4				License r					signed (Month,		
	12	7	30. Name and address of person who		of death (Iter	n 23a) (Tune B		2330	8			DECE	EMBER 7	, 200	4
			VICTOR PRIEGO, M					#41	00 E	BETHES	SDA, MI	20	817		
	Stat Registra		31. Date filed (Month, Day, Year) DEC 14 20		gistrar's Signa	ature	Spar	K							

			1 - For State Registrar	State of Ma	aryland / Dep	artment of F			ene 004	41957
	Physici /Medic		1. Decedent's Name (First, Middle, La Joseph	st)	Black			2. Date of Death Month	Day Year	
1	Examin		4a. Facility Name (If not institution, gir	e street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Dea	
			Renaissance Garde				zer Sprin		Montgome	ery
	Funeral Director		577-09-0100	Sex 7. Ag 1⊠M 2□F	e (In yrs. last birthday) 94 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 13,		rthplace (State or Foreign country) razil
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	B-1 sh	tor	Maryland Mont	gomery	Silver	Spring				1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number	<u></u>		10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23e		3126 Gracefield			20904			USA	
920	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. and they filen. The Madical Establish control to Madical Establish control to Madical Establish control to modified at event.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 17 Yes 2 1	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occup	durina most of wor	rkina 16	6b. Kind of Business	s/Industry
121	within ene. then *	ldmo	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired	3)			
d 2	ifiled Hygi other ant, II	a l	17. Father's Name (First, Middle, Last)	br	lck Layer	18. Mother's Nan	ne (First, Middle, Ma	Masonry aiden Sumame)	
Maryland	should be ad Mental marked c matic eva	To B	Joseph Black				Helen	Simpson		
lar)	2 shoul and Me is mark		19a. Informant's Name/Relationship	Type, Print)				ıral Route Number, (-	
	1 and Health am 27 ther tr		Hazel Black/ Wit	e	3126 20b. Place of Dispo		ld Road,	Silver Sp	pring, MD	
mor	Pages nent of int: If its		1 ☐ Burial 2 【Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		Metropo]	natory or other plac .itan	Decer 200	mber 13	,	, Virginia
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic enones.		21. Signature of Funeral Service Lice		/ Crema	Name and Addres	ss of Facility			, virginia
<u> </u>	88 188		Muan	Jal	50	Univer	sity Blvo	Funeral I	ver Sprin	g, MD 20901
1	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	10.	D		•	it,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	aDue to (or as	a consequence of):		eumo)		I week.
	LAdillilei	ē	Sequentially list conditions, if any, leading to immediate	b. Ad Due to (or as	vancec a consequence of):			ers D	isease	
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Aa	ult	ailure	to H	1200		
, 0,	licate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of):)				
68760,	cate b physic the b	edical	•	d						
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of de	livery
	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown		Ectopic pregnancy Other (specify)		-	Month	Day Year
	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant conditions	ontributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		_	the cause of death?
Vital Records,	w require been signature should b							1 ☐ Yes	2 No 3 Pr	robably 4 Unknown
3ec	0 4 0	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
la	ician: The certificate ha	e Co	25. Was case referred to medical					1☐ Yes 2⊡		2016
⋚	ysician: is certific director,	0 8	examiner?	Hospital:	nt 2 ER/Outpatien	t 3 DOA Othe	200	th <i>(Check</i> on <i>ly one)</i> ome 5 ☐ Residenc	on 6 MOther (6-e	-:4.1
υot	ig Phys ter this neral di	T:u	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	v 28b. Time of	28c. Injury Work		28d. Describe how		Спуј
sior	Attanding Physician: r death. actor: After this certific by the funeral director.	catio	2 Accident investigatio	1	, injury		Yes 2 No			
Division	To the Hospitel or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the tuneral	Certification:	4 Homicide determined	28e. Place of Inju building, etc	rry - At home, farm, stre :- (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	n 24 hou n 24 hou na Funai	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or inv ted.	occurred at the tim estigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the vithiu comp	M	29b. Signature and title of certifier	1/		29c. License			. Date signed (Monti	
	3+1		hoven Pu				9524	D	ecember	13,2004
	ンハ		30. Name and address of person who LOVEEN J PUTHUN	completed cause of de 1ANA, 3110	GRACE FI	ELD ROAD	, SILVE	RSPRING	5, MD 20	904
	Sta Registr	-	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	South				

	1 State Registrar	Ce	rtificate of Death		2004 41958
ysician	Decedent's Name (First, Middle, Last) AAD TE	Dirmi ED		Date of Death Month	Day Year 3. Time of Death
Medical	EVELYN MARIE 4a. Facility Name (If not institution, give street as	BUTLER	4h City Tourn or Leasting of Death	December	16 2004 1:05 PM
aminer	DOCTOR'S COMMUNITY H	·	4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGE'S
eral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	
ctor	215-36-3267 ^{1□ M 2}	F 64 Yrs.	Months Days Hours Min.	(Month, Day, Y	ear) 9. Birthplace (State or Foreign Country) 6 1940 Washington, D(
	Usual Residence of Decedent 10a. State 10b. County	100 Cit. T.			
or a		10c. City, Town or L			10d. Inside City Limits 1⊠Yes 2□No
Funeral Director	MD Prince Georg 10e. Street and Number	e's Landov	10f. Zip Code	140	
eumatic event, the Medical Exeminer must be notified at To Be Completed by Funeral Director	6406 Southland Drive		20785		Citizen of What Country?
era	11. Marital Status 12. Was	Decedent Ever in U.S. 13.			14. Race - American Indian,
큔	1 Never Married 2 Married 1	Yes 2 XINO	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
d by	3 ☑ Widowed 4 ☐ Divorced Yea	s, Give r or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: Black
Completed	15. Decedent's Education (Specify only highest grade comple	eted) 16a. Dece	dent's Usual Occupation kind of work done during most of work	ino 16I	b. Kind of Business/Industry
Be Completed		ege (1-40r 5+)	kind of work done during most of work DO NOT use retired)		
ပိ	12th 17. Father's Name (First, Middle, Last)	Chi	ld Care Provider	e (First, Middle, Mai	Private
9 Be		rley		ie Newman	
2	19a. Informant's Name/Relationship (Type, Prin.		ng Address (Street and Number or Rura		
T	Michael Edward Butl		Fox Hall Road Clir		
	20a. Method of Disposition	20b. Place of Dispo	esition (Name of		c. Location - City or Town, State
	1 □XBurial 2 □ Cremation 3 □ Removal '4 □ Donation 5 □ Other (Specify)	Irom State	natory or other place) Lion Cemetery 12/2		inton, Maryland
ej ej	21. Signature of Furieral Service Licensee		2. Name and Address of Facility J.]		
any injury or other treu once.	X.D. Hunha	11	474 Landover Road	Landover.	Maryland 20785
clan/Medical Examiner	Sequentially list conditions, b. ff any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c.	e to (or as a consequence of): e to (or as a consequence of): e to (or as a consequence of):	vorver extance	<i>~</i>	Onset and Death
Physiclan/Med	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Ď	Part II. Other significant conditions contributing	to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Completed	L			24a. Was an	24b. Were autopsy findings available
Com				autopsy performed	? prior to completion of cause of death?
Be	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	No 1 □ Yes 2/10 No
2	1 ☐ Yes 2 ☐ Hospital:	1 Impatient 2 ER/Outpatien	O#		6 ☐Other (Specify)
- in	27. Manner of Death 1 Natural 5 □ Pending (Date of Injury Month, Day Year) 28b. Time of Injury		28d. Describe how in	
cati	2 Accident investigation		M 1 Yes 2 No		
Certification:	determined 286. F	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
w	29a. Certifier 1 Certifying Physician: To	o the best of my knowledge, death the basis of examination and/or inv manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the cause	o(s) and manner as stated. and place, and due to the cause(s)
dical C	one) and	manner stated.			Date signed (Month, Day, Year)
Medical C	29b. Signature and title of certifier		29c. License number		
	, which	mN			
	29b. Signature and title of certifier Ellies ()	Cause of death (Item 23a) (Type 1			
Medical C	29b. Signature and title of certifier Ellies ()	MD cause of death (Item 23a) (Type, I			December 16, 2004 MD 20770

			For State Registrar	State of	of Marylai	nd / Depa <i>Cel</i>	artmei <i>rtifica</i>	nt of H <i>te of I</i>	ealth a D <i>eath</i>	and Me	ntal Hy	gierje Reg. No.	0 0 1	41959
	_		Decedent's Name (First, Middle,	Last)						2	. Date of De	ath		3. Time of Death
	Physici /Medic		Jimmie Brus	ter							Month Dec	13	2004	
	Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City	, Town, or	Location o	f Death		4c.	County of De	ath
				NURSING			Rix	rerda	1e	0411-				George's
	Funeral			i.Sex 1 □ M 2 🗗 F		. last birthday) Yrs.	Months Months	Days	Hours	Min.	. Date of Bir (Month, Da	th ay, Year)	9. Bi	rthplace (State or Foreign
	Director		578-34-6092 Usual Residence of Decedent		85	113.					June	4 19.	19 500	ith Carolina
	show adul		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Many ind	tor	MD Prince	George'	s	Landov	er							1⊠Yes 2□No
	or 28g	irec	10e. Street and Number				10f. Z	ip Code				10g. Citi	izen of What C	Country?
	23a (ai 🖸	6814 Forest Ter	race			1	20785					S.A.	
	after dea or itama	nel	11. Marital Status	Armed Fe		J.S. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	spanic Orig n, Mexican	gin? (Speci , Puerto Ri	fy Yes or No can, etc.))-	 Race - Am Black, Wh 	
36	72 hours after death with the Maryland natural; or itema 23a or 28a-f show iteal Evants at Irust be multified at	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ☐ Yes If Yes, Gi Year or D	ive		1 🗆 Yes	2 No	Specify:				Specify: D	11-
21215-0036	hour	ed t	15. Decedent's		7a(65.	16a. Dece	dent's Usi	ual Occupa	ation			16b. Ki	ind of Busines	lack s/Industry
15	n n	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed)	1-4or 5+)	(Give	kind of w DO NOT	ork done d use retired	furing most)	of working	1			
212	d within giene. or than "	mo;	8th	Conega (1-401 34)	Dor	nesti	.c				Pr	civate	
	al Hyg	Be	17. Father's Name (First, Middle, La	est)							First, Middle	, Maiden	Sumame)	
ylai	Ment Ment arkec	Tol	James Andrew She								11and			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. If the marked other than "natural", or itama 23a or 28a-f shoo item 27 is marked other than "natural", or itama 23a or 28a-f shoo other traumatic event, Ita Madical Evanti act rough be notified at		19a. Informant's Name/Relationship										r Town, State,	
_	1 and 2 Health tem 27 other tra		Gloria B. Hall,	/Daughte:		Place of Dispo			l'erra	се La			aryland ocation - City o	
Jor	toff:		1 Surial 2 ☐ Cremation 3		State	cemetery, crei	matory or	other plac					111.6	
Baltimore,	artmer artmer ortant injury		 4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie 		L	incoln				12/20			riand,M Funeral	Maryland
Ba	permit. Pages 1 and Department of Heali important: If item 2 any injury or other 2006.		XiDi W	Jarshu	u_									d 20785
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that	caused the dea	ith. Do not ent	ter the mo	de of dyin	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Asp	iration	Pneumo	onia							Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):								
18	LAdiliniei	Ļ	Sequentially list conditions,	D	entia (or as a conse	augus of:								
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	5000	(OI as a COIISE	quence on.								
	al-trai	xar	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):								
68760,	icate be executed physician and s the burial-transit	edicai Examiner		d.										
89	g phy g sthe													
Вох	death certific e attending p id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant		itcome of pregr birth 2 Fet		Ectopic r	oregnancy				2	23d. Date of de	
	0 0 0	Physician/M	in the past 12 months?		nant at time of		Other (s						Month	Day Year
P.0	ires that the de signed by the a d be detached t		9 Unknown Part II. Other significant condition	e contributing to a	leath but not re	sulting in the u	nderhina	Called and	on in Part I		23e Did t	obacco u	se contribute	to the cause of death?
	iaw requires that the as been signed by th 2 should be detache	by	Pait II. Other significant condition	a contributing to c	ieath but not re	saling in the u	riderlying	cause give	mini aiti.			Yes 2[Probably 4XJUnknown
Ö	w requir been si should	etec									24a. Was		24h Wasa	utopay findings available
of Vital Records,	The law	Completed									auto		prior to death?	
a	T Te	e Co	25. Was case referred to medical						OC Disease	of Dooth /	1 Yes		1 □ Ye	s 2₩ No
Ξ	Physician: r this certifica ral director, p	To Be	examiner?	Hospital:	Inpatient 2	TER/Outpatier	nt 3 🗆 D	OA Othe	20		Check only o		3 □Other (Spe	ecify)
	g Phy er this eral c	n: T	27. Manner of Death	28a. Date		28b. Time of Injury		28c. Injury Work			d. Describe	*		
jo	Attending r death. ector: After by the fune	atio	1 ☑ Natural 5 ☐ Pending investiga	tion	iai, bay roar,	injury	М		Yes 2 1	No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 200. Flaci	e of Injury - At I	nome, farm, str	eet, facto	ry, office		28	f. Location (City or To	Street and wn, State,	d Number or F)	Rural Route Number,
	ital or urs afte rai Dir lled in													
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 🔀 Certifying (Check only 2 🗍 Medical Ex	Physician: To the caminer: On the b and mar	e best of my kn pasis of examin nner stated.	iowledge, deati ation and/or in	n occurred vestigatio	at the tim n, in my op	ne, date and pinion, deal	d place, and th occurred	a due to the at the time,	date and	and manner a place, and du	is stated. le to the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	number					nth, Day, Year)
			1841	200	MI			D482	213			10	2-17-	2004.
01	(3)		30. Name and address of person with					-						
<u> </u>	<u> </u>		Neelam Ashai M.I				andov	er H	ills l	Mary1	and 20)784		
	Sta Registr		31. Date filed (Month, Day, Year) OFC 1 7 20		Registrar's Sign		11.							

			For State Registrar	State of N	•	epartment of Certificate of		nd Mental Hyg	211116	41960				
		3	Registrar 1. Decedent's Name (First, Middle,	Last)		Jertineate of	Death	2. Date of Deat		3. Time of Death				
П	Physici /Medic		Rita M. Ba	ggott				Decembe	r 11 2004	5:45 P M				
n Let	Examin		4a. Facility Name (If not institution,	give street and number		4b. City, Town,	or Location of I	Death	4c. County of Death					
		£	Southern Ma		pital Age (In yrs. last birth	day) If Under 1 Yea	Clintor			e George's				
	Funeral Director		577-62-7990	1 ☐ M 2 🏋 F	-	rs. Months Day		Min. (Month, Day, Mar. 10		nplace (State or Foreign untry) ash., DC				
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits				
	Maryla f shov	ror	DC				Washir	ngton		1 XYes 2 No				
	I within 72 hours after death with the Maryland liene. r than "naturel", or Itema 23a or 28a-f show The Medical Estabiliser count be notilised at	Director	10e. Street and Number 3811 V St.,	S.E. #30	12	10f. Zip Code	20020	1	Og. Citizen of What Co	•				
	me 23	Funeral	11. Marital Status	12. Was Deceder		13. Was Decedent of	f Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White					
36	or Ite	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2√0 If Yes, Give]No	1 ☐ Yes 2√ N		auto Hibari, oto.,	Specify: B1a					
21215-0036	ture!		15. Decedent's	Year or Date:	16a. [Decedent's Usual Occ	upation		16b. Kind of Business/l					
215	within 72 ene. than "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c		Give kind of work don life. DO NOT use reti	red)		C					
			17. Father's Name (First, Middle, L.	Z actl		Educ	ational	s Name (First, Middle, I		rnment				
Maryland	ed all	To Be		d Baggott			, o. mound		V. Johnson					
ary	should h	+	19a. Informant's Name/Relationshi		19b.	Mailing Address (Stre	et and Number		, City or Town, State, Z	lip Code)				
	s 1 and 2 f Health a ftem 27 is other tra		LaTarsha M. Ba	iggott/Daug			land Rd.	., #203 Sui		20746				
Baltimore,	Pages 1 nent of H int: If Itel iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		te cemetery	Disposition (Name of , crematory or other p			20c. Location - City or					
Itim			4 □ Donation 5 □ Other (Sp.21. Signature of Furgeral Service L		Lincol	n Memorial 22. Name and Add		12/21/2004 Stewart F	Suitland uneral Home					
Ba	permit. Departr Importe any inje		I ohm T.	Stewart	, III			Rd., N.E. W	ash., DC 20					
	• %	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.												
	Pnysician /Medical	i	Immediate Cause (Final disease or condition resulting in death)	a	Cerr	-	5. 10	M		Onset and Death				
	Examiner				as a consequence o	BP								
	D #	ner	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consquence o	111								
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	As a consequence o	n:								
8760,	ate be executed only sician and the burial-transit			1 156×	00 711	o .ccl	200e							
9	tificate ig phys as the	ledic		u										
Вох	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnar			23d. Date of deli Month	very Day Year				
0	that the dealed by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	4⊟Pregnan 9⊟Unknown	t at time of death	5 ☐ Other (specify)								
۳,	res that signed by be deta	by Ph	Part II. Other significant condition	s contributing to deat	h but not resulting in	the underlying cause	given in Part I.	23e. Did to	bacco use contribute to					
ords	w require been sig should b	ted t						1 Q Y	es 2□No 3□Pro	obably 4 Unknown				
Records,	e law r has be je 2 sh	Completed						24a. Was a autops perfori	sy prior to d	topsy findings available completion of cause of				
alF			25. Was case referred to medical				26 Place	1 ☐ Yes	2MNo 1 ☐ Yes	2 No				
Vital	Physicien: this certific ral director,	o Be	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inp.	atient 2 ER/Out	patient 3 DOA	Othor		ence 6 ☐Other (Spec	cify)				
n of	ding Phys. 1. After this funeral	n: T	27. Manner of Death N☐ Natural 5 ☐ Pending	28a. Date of I (Month,	njury 28b. Ti	jury V	ijury at Vork?		ow injury occurred					
Division	Attending or death. ector: After by the fune	icati	Accident investig	ot be 280 Place of	Injury - At home far	m, street, factory, offic	Yes 2 N		treet and Number or Ru	ral Route Number.				
Div	after Direct	Certification:	4 ☐ Homicide determin	building,	etc. (Specify)	in direct, leaving, one		City or Town	n, State)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edicai C			s of examination and				ause(s) and manner as late and place, and due					
	To the H within 24 To the Forcemplete	Me	29b. Signature and title of certifier	A2		29c. Lice	ense number	2	9d. Date signed (Month	Day Year)				
) left and	415		Do	02420	8	000	#1101				
R	(3)		30. Name and address of person v	who completed cause	of death (Item 23a) (Type, Printi	6000	de your	124	AND BOOK STATE				
	St	ate	31. Date filed (Month, Day, Year)	₩ V P Reg	istrar's Signature	<u> </u>	TIN	me sec	121					
	Regist		DEC 2 0 2	104 Been	N. K.	book								

			For State Registrer	State of	Maryland / C		ment of H iicate of I		and Me	ntal Hygie		41961
	Physici /Medi	cal	Decedent's Name (First, Midd Simin Barbour							Date of Death Month Dec. 12,	Day Year 2004	6:04p M
	Examir	ner	4a. Facility Name (If not institution 5301 Westbard		19 <i>1</i>)	4b	. City, Town, or Ret	hesda			4c. County of De Montgor	
	Funeral		5. Social Security Number		Age (In yrs. last birt	NA/	Under 1 Year onths Days	If Under 2		. Date of Birth (Month, Day, Ye	9. B	rthplace (State or Foreign
	Director		577.06.5745 Usual Residence of Decedent	1 M 2∆A+	66	rs.	Onitins Days	riours		ec.20, 1		shad,Iran
	land ow		10a. State 10b. County	<i>y</i>	10c. City, Town	or Location	on					10d. Inside City Limits
	a-f sh	ctor	MD Montg	gomery	Beth	resda						1 ☐ Yes 2 📉 No
	or 28	Director	10e. Street and Number			1	0f. Zip Code			10g.	Citizen of What C	Country?
	s 23s		5301 Westbard				2081				U.S.A.	
980	be filed within 72 hours after death with the Maryland tal Hygiene. I do other then "natural", or liems 23s or 28s-f show event, I're Modical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mai 3 □ Widowed 4 👿 Divorced	If Yes Give	∌ş? (X No		Decedent of Hi s, specify Cuba Yes 2 X No	spanic Orig n, Mexican Specify:	gin? (Specif , Puerto Ric	fy Yes or No- can, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	within 72 ho ene. than "natu he Madical	Completed		nt's Education est grade completed) College (1-4	or 5+)	(Give kind life. DO N	s Usual Occupa of work done of NOT use retired,	luring most)	of working	16b	. Kind of Business	s/Industry
id 2	illed Hygi other	Be Co	17. Father's Name (First, Middle,	Last)		педа.	Decre		r's Name (F	First, Middle, Maid		
/lan	should be filed vand Mental Hygie and Mental Hygie amarked other tumatic evant, II	To B	Nosratollah Gha	deri-Arab				Z	ahra	Zia Al S	adat Mir	fendereski
/an	2 sho and l		19a. Informant's Name/Relations	ship (Type, Print)	19b.	Mailing Ad	ddress (Street a	und Numbei	r or Rural P	Route Number, Cit	ty or Town, State,	Zip Code)
e,	1 and Health em 27		Marcus Barbour 20a. Method of Disposition	/ Son	20b. Place of		ronforg	e Cou	rt D		MD 20855 Location - City o	
m Om	ont of our filting		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		te cemetery	r, cremator	ny or other place Mem. Pa:				ckville.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic events.		21. Signature of Funery Service		V	22. Na	me and Addres	s of Facility	Josep		's Sons,	
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cau	sed the death. Do no	ot enter the	e mode of dying	, such as o	cardiac or re	espiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_a Cardi	o Pulmona	ry Ar	rest					Onset and Death
	/Medical Examiner		resulting in death)		as a consequence of	,	.1					
		Jer	Sequentially list conditions, any leading to mine alle cause. Enter Underlying Cause (Disease or injury		e Rhemato		ctnriti	S				
	cuted	Examiner	trial miliated events	_{c.} Emphy	sema							
8760,	icate be executed physician and s the burial-transit	EX	resulting in death) Last	Due to (or	as a consequence of	f):						
687	icate physics the t	edical		d								
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12_months? 1							23d. Date of de Month	3d. Date of delivery Month Day Year	
Δ.	res that igned b be deta	by Pl	Part II. Dther significent condition	ons contributing to death	but not resulting in	the underly	ying cause give	n in Part I.		23e. Did tobacc	o use contribute t	o the cause of death?
ord	w require been sig	ted								1 🗆 Yes	2 □ No 3 □ P	robably 4 XUnknown
Vital Records,		Completed								24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 \(\square\$\) No
	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	atient 2 ER/Outp	national 20				heck onlone		
l of	g Phys er this seral di	n: To	27. Mapner of Death	28a. Date of I		me of	28c. Injury	at		. Describe how in	6 □Other (Spe	ecify)
sior	Attending F or death. ector: After by the funera	atio	1 Natural 5 Pendir investi	gation	Day 16ai) III	ury N	Work'	r es 2□N	lo			
Division of	or A office of in by	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Place of	Injury - At home, farr etc. (Specify)	n, street, fa	actory, office		28f.	Location (Street City or Town, Sta		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	5.10	ng Physicien: To the be Exeminer: On the basis and manner	st of my knowledge, s of examination and/ stated.	death occi or investig	urred at the time pation, in my opi	e, date and inion, death	place, and occurred a	due to the cause at the time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To To	2	29b Signature and the of certifie				29c. License D29224				Date signed (Mont	h, Day, Year)
,	5		20. Name and address of	who nomeleted	f death (trans con)			•			2/12/04	
		1	30. Name and address of person S. Jamshidi,		Leesburg			/ienna	η. 17Δ	22182		
	Sta Registra		31. Date filed (Month, Day, Year) DEC 15	32. Regi	strar's Signature		Sparks		VEL_	22102		

State of Maryland / Department of Health and Mental Hygiene

		·	Certificate of Death	Reg. No.	+ 41962		
	Physiciar	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death		
4	/Medica	Allierre	Brock	December 20, 200	4 4:45 AM		
×	Examine	4a Fecility Neme (If not institution, give street and number)	4b. City, Town, or Lo	,, c	th		
		Cumberland Villa Nursing Cent			gany		
ı	Funeral Director	5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 817 81	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bir (2) 12/28/1922 Mi	thplace (State or Foreign ountry) SSOUTI		
	pu *	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits		
	Ba-f sho	MD A11	LaVale		1 ☐ Yes 2 ☐ No		
	ifier death with the Mei r items 23a or 28a-f si niner must be notified	10e. Street and Number 67 LaVale Court	10f. Zip Code 21502	10g. Citizen of What Co	USA		
020	filed within 72 hours effer death with the Meryland Hygiene. ther than "natural", or items 23a or 28a-f show but, the Medical Examiner must be notified at a Commission in France in Discrete.		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1□ Yes 2箇 No Specify:	cify Yes or No- Rican, etc.) 14. Race - Am Black, Whi	Black, White, etc.		
5-0	72 hr	15. Decedent's Education 16 (Specify only highest grade completed)	Se. Decedent's Usual Occupation (Give kind of work done during most of workii life. DO NOT use retired)	16b. Kind of Business	/Industry		
121	iene. The Me	Elementary/Secondary (0-12) College (1-4or 5+)					
2	be filed withintal Hygiene. d other than event, the M		Homemaker	(First, Middle, Maiden Surname)	er		
Maryland 21215-0020	Mental Mental urked o	Т 1	Mary	Duke			
Mar	0 0 0	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rure				
e)	s 1 end 2 f Heelth item 27 i		1001 Youman Drive, Lav		L502		
altimore,	or of	1 2 Buriai 2 Cremation 3 Chemoval from State	of Disposition (Name of tery, crematory or other place)				
ij	Depertment Important: Important: In y injury once.	4 □ Donation 5 □ Other (Specify) 21. Signature of unital Service Licensee	View Cemetery 1/2/ 22. Name and Address of Facility Ada	22/2004 Cumberla			
Ba	permit. Peges Depertment of Firmportant: If its any injury or of once.	Labort C. Celence	· ·	et, Cumberland, MI	•		
		23a. Part1. Enter the disease, or complications that caused the death. Deshock, or heart feilure. List only one cause on each line.	o not enter the mode of dying, such as cardiac o	respiratory arrest,	Approximate Interval Between		
	Physician				Onset and Death		
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Selevosis		years		
		Due to (or as	e consequence of):				
Т	executed in end hel-trensit	b					
Ć,	ficete be executed physician end st the buriel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of):				
68760,	ficete be physician sthe buri	Cause (Disease or injury that initiated events Due to (or as a	a consequence of):				
×	in e	resulting in death) Last					
Bo	at the death ced by the attend leteched for us.						
o.	the de ched	Part II. Other significant conditions contributing to death but not resulting	, , ,	23b. Did tobacco use contribute			
Ω.	te de de		- metastoris	1 ☐ Yes 2 2 AMO 3 ☐ P	robably 4 Unknown		
Records,	requir been s should	to Chest		performed?	Were autopsy findings available prior to completion of cause of death?		
æ	The level ete has pege 2			1□ Yes 2LiNo	1 ☐ Yes 2 ☐ No		
Vital	ystcien: The secutificate director, peg	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
ot C	\$ 10 E	Hospital	Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 ☐ Residence 6 ☐ Other (Spe	cify)		
	Attending Ph or deeth. octor: After th by the funerel	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Dey Year)	. Time of 1 28c. Injury at 2 2 Work? 1 Yes 2 No	8d. Describe how injury occurred			
Division	tal or Attending P is efter deeth. al Director: After t ed in by the funere Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office 2	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
_	Hospi 14 hours Funer tely fill	29a. Certifier (Check only one) 1 ✓ Certifying Physicien: To the best of my knowledge of examination a and manner stated.	ge, death occurred at the time, date and place, a und/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as d at the time, date and place, and due	s steted. to the cause(s)		
	within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)		
	6 ₹ 6 0	b. emp	D0054411	December 2			
	3	30. Name and address of person who completed cause of death (Item 23a	(Type Print)				
	. 4		emorial Avenue, Cumber	land, MD 21502			
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	dumber	rande in ZIJUZ			
	Registrar	DEC 2 1 2001 heneva	B Sparket				

			For State Registrar	State of M	-	epartment of Certificate of		nd Mental Hyg	giene 2001	4 41963		
	Physici /Medic		Decedent's Name (First, Middle,		nrad Brode			2. Date of Dea Month Decen	nber 19, 2004 ^{Yea}	3. Time of Death 6:40 A. _M		
T.	Examin		4a. Fecility Name (If not institution, St. Vinc	give street and number ent de Paul Nur	sing Center	4b. City, Town	n, or Location of E Fr	Death ostburg	4c. County of Death Allegany			
	Funeral Director		5. Social Security Number 220-16-7020 Usual Residence of Decedent	5. Sex 7. A 1 ∑ M 2 □ F	ge (In yrs. last birtho 78 Yrs	Months Da		Hrs. 8. Date of Birti (Month, Day October 2	(, Year)	Birthplace (State or Foreign Country) Frostburg		
	Maryland a-f ehow	tor	10a. State 10b. County	llegany	10c. City, Town o	r Location	ing		10d. Inside City Limits 1			
	h with the 23a or 28s	ai Director	10e. Street and Number 40	Main Street		10f. Zip Cod	21539		10g. Citizen of What	g. Citizen of What Country?		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If item 27 te marked other than "neturei; or items 23a or 28a-f ehow eny injury or other traumatic event, It a Madical Examiner must be notified at once.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🎘 Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces d 1 XYes 2 [If Yes, Give Year or Dates	No	13. Was Decedent of If Yes, specify C		1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. White		
	d within 72 ho piene. r than "netur It e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Q 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist					16b. Kind of Business/Industry Factory				
land ?	utd be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, L	ast) Charles Albert I	Brode		18. Mother's	Name (First, Middle, Be	Maiden Sumame) essie Simson			
Baltimore, Mary	and 2 shoilaith and N 27 le ma er trauma		19a. Informant's Name/Relationsh James E. Mcl	p (Type, Print) Kenzie-Friend	19b. M	lailing Address (Str		or Rural Route Number Street, Lonacon	-			
	Pages 1 and the ment of He ant: If item ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp		e cemetery,	isposition (Name of crematory or other Gap Veterans	place)	December 21, 2004	20c. Location - City Flintsto	or Town, State ne, Maryland		
Balt	permit. Departi importi eny inj		21. Signature of Funeral Service L	Mohage			lcKenzie Fun			aconing, Md. 21539		
	Pnysician /Medical		23a. Part1. Ertler the disease, or of shock, or shart failure. List of immediate Cause (Final disease or condition resulting in death)	nly one cause on each	ed the death. Do not line.	ms L	dying, such as ca		rest,	Approximate Interval Between Onset and Death		
8760,	cate be executed by physician and stee burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of) s a consequence of)							
.O. Box 68	ne death certif the attending thed for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ∐Fetal death at time of death	3 □Ectopic pregna 5 □ Other (specify			23d. Date of o	delivery Day Year		
<u>α</u>	res that Igned b	ξ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death			
Il Records,	The ate ha	Completed						24a. Was autop perfor	sy prior t med? death	autopsy findings available o completion of cause of ?		
of Vital	Phyalcien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 100	Hospital: 1 Inpai		Itient 3 DOA	Other: Nursi	f Death <i>(Check only o</i> ling Home 5 \square Resid		оөсify)		
Division o	ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending investig: 2 Accident 3 Suicide 6 Could near determined	ot be 28e. Place of Ir	jury 28b. Tim lnju njury - At home, farm atc. (Specify)	ry M	njuryat Work? 1 □ Yes 2 □ No ice		ow injury occurred Street and Number or	Rural Route Number,		
Ö	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physician: To the bes	t of my knowledge, o			place, and due to the o	ause(s) and manner			
	3	Medical	one) 29b. Signature and title of certifier	and manner s			ense number		29d. Date signed (Mo	onth, Day, Year)		
رر) (Fra)		30. Name and address of person w		death (Item 23a) (Ty		im les		PesThur	and xizz		
	Sta Registi		31. Date filed (Month, Day, Year) DEC 2 1	2004 32. Regis	trar's Signature	& Sou	uks					

		1	For State Registrar	S	tate o	f Maryl		-	rtment			and M	ental Hy	/giene Reg. No	6.1	004	L	1964
			1. Decedent's Name (First, Middle	, Last)					-				2. Date of Di Month	eath Da		Year .		e of Death
	Physicia		Leonard				E	Bear	d, S	r.			12	- 13	<u> </u>	04	20	:45 M
1	/Medic Examin		la. Facility Name (If not institution	, give stree	et and nu	mber)					Location					y of Death		
			SACRED HE	AR7	-	405K	ITA	4	CL	ME	BER		0	1	44	EGF		
	Funeral		5. Social Security Number	6. Sex	م ح		yrs. last birtl		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, D 02/08	irth ay, Year)	0	9. Birthp	place (Stantry)	ate or Foreign
	Director		220-03-7001	1 🖾 M	2 F	85	Y	rs.					02/08	/191	9	Mary	land	
	2	<u> </u>	Usual Residence of Decedent 10a. State 10b. County			100	City, Town	orloc	ation							1	Od. Insid	le City Limits
	arylar show	.	10a. State 10b. County Alles	anv		100			rlan	f								Yes 2 □ No
	Ba-f	octo		5					10f. Zip	Codo				10a Cit	tizen of	What Cour	ntry?	
	vith th	Director	10e. Street and Number 58 Marion St	reet					TOI. ZIP		1502			109.01	US			
	within 72 hours after death with the Maryland ene. Than "natural" or Items 23a or 28a-f show ha Medical Examinar main be notified at	rai			Man Don	edent Ever	in II S	12 14	Jac Deced	ent of Hi	enanic Or	igin? (Sne	cify Yes or N	lo-	14. Ra	ce - Americ	can India	n,
	er de item	Funeral	 Marital Status Never Married 2 Marr 		Armed Fo			13. 11	Yes, spec	ify Cuba	n, Mexical	, Puerto	ecify Yes or N Rican, etc.)			ack, White,		
9	rs aft	by	3 ☐ Widowed 4 ☐ Divorced	160	If Yes, Gi	ve	.945	1	☐ Yes	2 No	Specify:				Speci	ify:	Blac	k
9500-GLZLZ	hour	edt	15. Deceden	r's Educati			16a.	Decede	ent's Usua	I Occupa	ition			16b. K	and of E	Business/In		
Ų	In 72	Completed	(Specify only highes	st grade co	mpleted)		_	(Give k	kind of wor	rk done d se retired,	luring mos)	t of work	ng					
7	with iene.	Eo	Elementary/Secondary (0-12)		College (1-4or 5+)			Lif	t Op	erato	r			Tir	e and	Rub	ber
	filed Hygid other ent, I	BeC	17. Father's Name (First, Middle,	Last)							18. Moth	er's Name	(First, Middl	le, Maider	Suma	ime)		
Maryland	should be nd Mental marked c	To B	Thomas			Веа	rd				Mar	У	Εt	ta		Во	wers	
агy	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. It had also act 28a-f show item 21 is marked other than "natural" or items 23a or 28a-f show other transmite ovent, the Medical Evarth at mast be notified at other transmite event.		19a. Informant's Name/Relations	hip <i>(Type</i> ,	Print)								I Route Num			n, State, Zip	Code)	
Ž	1 and 2 Health a lam 27 ls		Scherry Brown	/ dau	ghte	r	3	39	01d	Iown	Road	l, Br	idgepo	rt,	CT	0660	6	
Baltimore,	s 1 a f Hei itam othe		20a. Method of Disposition			- I	b. Place of cemeter	y, crem	natory or o	ther plac	θ)		Date		ocation	- City or To	own, Sta	te
Ë	permit. Pages 1 Depertment of F Important: If Ita any injury or ot		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		oval from	State	1D Vet	. C	Cem @	Roc	ky Ga		/23/20			intst		
=	mit. I sertm sortal	1	21. Signature of Fundral Service	Licensee	~													e, P.A.
ñ	Depermination of the series of	W 9	Lout (10	elen	u			404	Deca	tur S	Stree	t, Cum	berl	and	, MD	215	02
			23a. Part1. Enter the disease, or shock, or heart failure. List	complicat	ions that	caused the	death. Do n	not ente	er the mod	e of dyin	g, such as	cardiac	or respiratory	arrest,			Approx	imate I Between
	Physician		Immediate Cause (Final	Offiny Office	1	10+	4	7.	or.	- H	- 10	C	0000	_			Onset	Pars
7	/Medical		disease or condition resulting in death)	_ a	Due to	Lor as a co	a sequence	of):	1		915		1166				24	FVII
	Examiner			Ι.	5	arco	ma	0	17	he	Lol	+ 1	eg.				5 Y	ears
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying) 0. –	Due to	(or as a co	nsequence	of):			J	-						
	ate be executed hysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events	\														
o,	an ar rial-ti		resulting in death) Last		Due to	o (or as a co	nsequence	of):										
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89	leath certificat attending phy 1 for use as th	Ned	IS SENALS.	1												- I.		
Box	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c.		utcome of problems of problems of the birth 2		3 🗆	Ectopic p	regnancy						ate of deliv Month	ery Day	Year
	0 0 2	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Preg	nant at time	of death	5 🗆	Other (sp	pecify)				-			,	
P.0.	requires that the de neen signed by the a hould be detached f	h.	9 Unknown										OZa Dia	d tebeses		ntribute to t	the earlie	o of death?
s,	8 5 0	by	Part II. Other significant conditi	ons contri	buting to	death but no	it resulting in	n the ur	nderlyi <i>n</i> g o	ause giv	en in Part	ŧ.	1		use co			4 Dunknown
Record	w require been sig should b													1 1 0 3	1			
900	aw 2 S	pie											24a. We	topsy	24b	prior to co	opsy find ompletion	lings available of cause of
	9 4 9	Completed											1 Tyes	rformed? 20⊠N	0	death?	20 No)
Vital	iclan: Th certificate rector, pag	Be	25. Was case referred to medica	ıl							26. Plac	e of Deat	h (Check onl)	y one)				
/	S O D	2	examiner? 1 ☐ Yes 2 No	Hos	pital:	npatient	2 ER/Ou	itpatien	ıt 3□ DO	Oth Oth	er: 4 🗆 N	ursing Ho	me 5 Re	sidence	6 🗆 0	ther (Speci	ify)	
J of	ig Ph ter th neral		27. Manner of Death		28a. Date (Mo	e of Injury onth, Day Ye		Time of njury		28c. Injur War	k?		28d. Describ	e how inju	ary occi	urred		
Division	Attending or death. actor: Atterby the fune	atic	2 ☐ Accident invest	igation					М	1 🗆	Yes 2]No						
Vis	ar de racto by th	tific	3 Suicide 6 Could 4 Homicide determ	not be nined		ce of Injury - ding, etc. (S		ırm, str	eet, factor	y, office			28f. Location City or T	(Street a Town, Stat		nber or Rur	ral Route	Number,
Ö	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:						1	1									
	Hospital 24 hours a Funaral I tely filled	(22	29a. Certifier Certifyi	ng Physic I Examine	r: On the	basis of exa	iminettien an	e, death	n occurred vestigation	at the tir	ne, date a pinion, de	nd place, ath occur	and due to the	ne cause(: e, date ar	s) and r	manner as : e, and due !	stated. to the ca	use(s)
	the H in 24 tha F iplete	ledic	one)		and ma	inner stated.	()									ned (Month,		
	To the within 2 To tha complet	Σ	29b. Signature and title of certifi		* .	4.40			29	C. Licens	e number	47	9	ł.		9/2	-	
•	5		beegs +						-	٥٥٠	/ () /	1 1	1	0	- 11	1116	30-	1
4	220)		30 Name and address of person				(Item 23a)	Туре,	Print)	1	1.1-	1.	0	(2,,,	sh.	info.	11	102(50
_			Colling	an,			10 1	117	NA	W	913	nK	000	wi	97 · A	ww	win	1111 (120
		ate	31. Date filed Month, Day, Year		1	Registrar's		6		/								
	Regist	rar	DEC 2	U ZUU4	+	1 hilling	~~	D	d	on	6/							

		1 - State Registrar 1. Decedent's Name (First, Middle, i	State of Ma		Departr		lealth a		lygiene Reg. No	2001	1 1 9 6 5 3. Time of Death		
Physic /Med Exam	ical iner	Edna Ellen Bittinger 4a. Facility Name (If not institution, s SACCED HER	give street and number)) HAL e (In yrs. last t	(. City, Town, or	r Location of CR Out	Death 4 Hrs. 8, Date of	Da 4c	County of Dea AlleGr	the tholace (State or Foreign		
Funera Directo		214-28-6365 Usual Residence of Decedent 10a. State 10b. County	1□M 2 ⊠ F 90	10c. City, To	Yrs. Mo	onths Days	Hours	Min. 11-May	/=1914 ^{r)}	Mar	10d. Inside City Limits 1 M2 Yes 2 □ No		
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f show event, the Medical Evanthar I was be multipled at	ai Director	Maryland Allega		Frostburg	1	Of, Zip Code			10g. Ci	Citizen of What Country?			
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, P			n? (Specify Yes or No- Puerto Rican, etc.) 14. Race - A Black, W			te, etc.			
d within 72 ho giene. ar than "natur the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or	5.1)	a. Decedent (Give kind life. DO I	s Usual Occup I of work done NOT use retired I ker	during most (d)		ho	memake	·		
	To Be (William Crowe Mary Mo 19a. Informant's Name/Relationship (Type, Print) 19b. Majling Address (Street and Number or F											
e, Mi		Paul Bittinger 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		20h Blaca	of Disposition			rostburg Date 22-Dec-2004	20c. L	ocation - City or	21002		
pernit. Pages Department of I Important: If ite		21. Signature of Funeral Service Li	Duri	7	Durst		lome, 5	7 Frost Ave.		ourg, MD	21532 Approximate		
Physician /Medica Examine stician and physiciansit	Examiner	23a. Part Lenter the disease, or control of the con	a	a consequence	DEP (se of): Acy se of):	ARI	IAC ERY	DISEAS!	Π 7	/-	Interval Between Onset and Death		
BOX 00 auth certificat attending phy for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d		opic pregnanc her (specify) _	у			23d. Date of delivery Month Day Year				
Hecords, F.C. he law requires that the de shas been signed by the ge 2 should be detached	leted by Ph		ES MELL		174	PERT		<u>\</u>	Did tobacco ☐ Yes 2 Was an	2 □ No 3 □ P	to the cause of death? Probably 4 Junknown Butopsy findings available		
	Be Completed	25. Was case referred to medical examiner?	ALUPE		UIZ ()			1 ☐ Y	піу опе)	prior to death? o 1 \(\text{Ye}	s 2 No		
JIVISION OT V I or Attending Physicater death. Director: After this of in by the funeral direction.	ုဝ	2 Accident investiga	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury						3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? M 1 Yes 2 No				
DIVISION OT VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ai Certification:	3 Suicide 6 Could no determin	building, e	tc. (Specify) t of my knowled	dge, death oc	curred at the ti	me, date and	City of	Town, Stat	e) s) and manner a	Rural Route Number,		
To the Hc within 24 I To the Fu completely	Medical	one) 29b. Signature and title of certifier	xaminer: On the basis of and manner's		and/or inves	29c. Licens	se number		29d. Da	ate signed (Mon	nth, Day, Year)		
ر ر چ Regis	State	30. Name and address of person w OR MARIT SIC 31. Date filed (Month, Day, Year)	the completed cause of the garage 32. Regist	death (Item 23)	100 L	WALSH	ROAC	1, Cumb	DERIA	nd, me	2 20, 2004		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Marguerite Blume 12 17:30 M 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND HOSPITAL SACRED HEART 8. Date of Birth (Month, Day, Jun 28, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F MD 220-28-9397 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examinar must be notified at 1 Tyes 2 No MD Allegany Cumberland Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 310 Williams Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Flementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wire Department of Health and Mental Hygienn Importent: If Item 27 is marked other than any injury or other traumatic event, ILE, ODGE. 12 real estate representative Twigg Realty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nyanza B. Biser Harper Boyd L. Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Williams Street Ronald Blume husband Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/27/2004 Cumberland Sunset Memorial Park MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EREBRAN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 9nknown HYPERTINSION Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ို 1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 SNatural 5 Pending М 1 Tes 2 No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerei Dira 29a. Certifier fff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mod DONALDSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

-		_	1- For State of Maryland / Depa Cert	rtment of Health and Metificate of Death	_	ne 2004 41968						
	Physic		Decedent's Name (First, Middle, Last) Trinidad Corpuz		2. Date of Death Month	Day Yeer 3. Time of Death 744-PM						
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 6500 Edgerton Drive	4b. City, Town, or Location of Death Lanham	12	4c. County of Death Prince George's						
Maryland 21215-0036	Funeral Director		5. Social Security Number 6. Sex 1 M 2 TF 7. Age (In yrs. last birthday) 94 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 2, 19							
	death with the Maryland ms 23e or 28e-f show I must be notitled at	ctor	10a. State 10b. County 10c. City, Town or Loc Maryland Prince George's	ation Lanham		10d. Inside City Limits 1 ☑ Yes 2 ☐ No						
	th with the 23e or 28	I Director	10e. Street and Number 6500 Edgerton Drive	10f. Zip Code 20706	10g.	Citizen of What Country?						
	hours after death turel', or Items 2	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 No	20/706 fas Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F Yes 2⊠ No Specify:	cify Yes or No- Rican, etc.)	USA 14. Race - American Indian, Black, White, etc. Specify: Filipino						
	within 72 hours after ane. than "neturel", or Ite	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give k life. Di	ent's Usual Occupation ind of work done during most of workin O NOT use retired)	g 16b	. Kind of Business/Industry						
land 2	be filed Ital Hygi of other event, L	To Be Co	10th 17. Father's Name (First, Middle, Last) Unk	Homemaker 18. Mother's Name	(First, Middle, Maid	Private den Sumame) Unk						
	nd 2 shallth and 27 is m	ř		Address (Street and Number or Rural Edgerton Drive, La								
() Baltimore,	Page: nent of ant: If		20a. Method of Disposition 1★ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crematery, ition (Name of Da atory or other place)	ate 20c	Location - City or Town, State							
	Departr Departr Importe any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706									
	Physician /Medical Examiner		23a. Paxi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximately account for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, niterval Onset a disease or condition resulting in death) Due to (or as a consequence of):									
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last b. NEUMONA Due to (or as a consequence of): C. Due to (or as a consequence of):									
9	artificate ing phys e as the	Medical	IF FEMALE:									
.O. Box	that the death certificated by the attending posterior detached for use as	Completed by Physiclan/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	ictopic pregnancy Other (specify)		23d. Date of delivery Month Day Year						
ords, P.	w requires that the been signed by the should be detach	ted by P	Part II. Other significant conditions contributing to death but not resulting in the und Hypertensive Cardiovascu	erlying cause given in Part I. LIAT DISCOSE		o use contribute to the cause of death?						
Vital Records,			Progressive Cognitive	Pecline	24a. Was an autopsy performed 1 ☐ Yes 2 Ø							
of Vita	ys ys	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death (/	6 COther (Specify)						
Division o	fing After fune	Certification:	27. Manner of Death 1 Matural 5 Pending investigation 2 Accident 6 Could not be	28c. injury at Work? M 1 \[Yes 2 \] No	d. Describe how in	jury occurred						
Divi	itel or Al ars after or rel Direc lled in by	Certifi	4 Homicide determined 28e. Place of Injury - At nome, farm, stree building, etc. (Specify)		City or Town, Sta	at						
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After gompletely filled in by the fune	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant manner stated.	ccurred at the time, date and place, an stigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)						
)	T witi	~	29b. Signature and title of certifier lands, mp	D 005 122		Date signed (Month, Day, Year)						
		12	30, Name and address of person who cor pleted cause of the ath (Item 23a) (Type, Pri ESME YONGO U. JUANITEZ, MD 31. Date filed (Month, Day, Year) 32. Reverar's Signature	- 1160 VARNUM	ST. NE	P. WASH. D.C. 20011						
	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 2 2004 32. Revierrar's Signature	assile								

			. (0)	artment of Health and Mer		ne 2004	41969
			Decedent's Name (First, Middle, Last)	2.	Date of Death		3. Time of Death
	Physicia /Medic		Alma Ruth Campbell	De	Month Cember	Day Year 19 2004	2:38A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			110 Oakwood Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Conowingo of Under 1 Year If Under 24 Hrs. 8.	Date of Birth	Cecil	(0) 1 5
	Funeral Director		203-07-1543 1 M 2 X F 83 Yrs.	Months Days Hours Min.	(Month, Day, Yo	ear) 9. Birth	place (State or Foreign htry) PA
			Usual Residence of Decedent		0071. 27,	1721	,,,
	nrylan show	_	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Be-f	Scto	MD Cecil Conowin	···			1 ☐ Yes 2 💢 No
	with t	Dir	10e. Street and Number 110 Oakwood Road	10f. Zip Code		. Citizen of What Cou	ntry?
	leath ns 23	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	21918 Was Decedent of Hispanic Origin? (Specify	y Yes or No-	SA 14. Race - Ameri	can Indian,
o	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examin ar must be multified at anone.		Armed Forces? 1 □ Never Married 2 □ X Married 1 □ Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Ric	an, etc.)	Black, White,	
3	ural', c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X☐ No Specify:		Specify: Whi	te
<u>.</u>	n 72 h	ompleted	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	168	b. Kind of Business/In	dustry
7	withir ene. then	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	nemaker	0	wn Home	
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	uld be fental rked ric ev	To B	Elam Kulp Burkloder	Ada Muer	s		
Mary	short and N Is ma	-		ing Address (Street and Number or Rural R	oute Number, C	,	Code)
o Z	and and m 27			Dakwood Road, Conowi	-		
0	ges 1 t of H If ite		1 A Burial 2 Cremation 3 A Hemoval from State	osition (Name of Date amatory or other place)	2004	c. Location - City or To	
altimor	it. Pa rtmen rtmit: njury			Mennonite Cemeteru	W.	illow Stre	et, PA
Ö	Dermi Depa Impo any ir		21. Signature of runnal solver Ellerisse Dordie	22. Name and Address of Facility R.T.	Fourd 1	Funeral Ho	me, P.A.
		-	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, br heart failure. List only one cause on each line.	11 S. Queen St., Rinter the mode of dying, such as cardiac or re			Approximate
	Physician		Investigate Asses (Final	1	1	1	Intervat Between Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	ocardial In	rare	1100	7744
	Examiner	_	Sequentially list conditions, if any leading to immediate b. At he roscient Due to (or as a consequence of):	erotic Cardiov	ascolo	ar Disouse	15 years
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				v
,	al-tra	Exar	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
2/00	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cai	d				
0	ng ph	ed	IF FEMALE:				
X Q Q	that the death certifi ed by the attending I detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delive Month	Day Year
5	the a	ysic	1 ☐ Yes 2 M No 9 ☐ Unknown 5 ☐ Unknown	Other (specify)			
7.	uires that the signed by to		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac		he cause of death?
Records,	quires n sign ald be	d by	Congestive Heart Fail	ure	1 🗆 Yes	2 X No 3 ☐ Prot	pably 4 Unknown
o S	s been si	ompieted	J		24a. Was an	24b. Were auto	psy findings available
ř	sicien: The law s certificate has t lirector, page 2 s	шо			autopsy performed 1 Yes 2 X		mpletion of cause of
VII	ien: artifica ctor, p	BeC	25. Was case referred to medical examiner?	26. Place of Death (C			
_	d sign	To	1 X Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			e 6 ☐ Other (Specif	y)
חכ	ding Physicien: h. After this certific funeral director,	ertification:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time tnjury	of 28c. Injury at 28d Work? M 1 ☐ Yes 2 ☐ No	I. Describe how	injury occurred	
UNISION	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, s		Location (Stree	et and Number or Rura	Il Route Number,
2	after after I Dire	erti	4 Homicide determined building, etc. (Specify)	,	City or Town, S	State)	
	To the Hospitel or Attending Pl within 24 hours atter death. To the Funerel Director: Atter to completely filled in by the funera	edical C	29a. Certifier (Check only (C				
	thin 2, the F mplete	Medi	one) and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month,	
	So T wil		Sylicities and this system of	D38861			
	i		30. Name and address of person who completed cause of death (Item 23a) (Type	Drint)		ecember	
	ا ا		DAUID HEXTER MD DME	106 Bos	Stree	+ Ellyon	MD 31921
	Sta	ite	21 Date Stad (Month Day Your) 20 Parietrate Signature		v —		1//
	Registi	rar	DEC 2:1 2004	Contract of the Contract of th			

			For State	State of Maryland	d / Depa	artmen		Mental Hy	giene	nni.	1.1070	
			Registrar 1. Decedent's Name (First, Middle, La	st)		uncai	e or beatir	2. Date of De	Reg. No.	- 0 0 %	3. Time of Death	
	Physici		Belle	Carlen				Decembe	er 9,	200 ^{Year}	7:23 A M	
4	/Medic Examin	_	4a. Facility Name (If not institution, giv			4b. City,	Town, or Location of De			4c. County of Death		
			13816 Blair Ston	e Lane		Si	lver Spring		M	ontgome	ry	
	Funeral		Social Security Number 6. S			If Under Months	r 1 Year If Under 24 H Days Hours Mi		th y, Year)	9. Birthp	lace (State or Foreign try) York	
	Director		111-26-4738 Usual Residence of Decedent	□ ^M 2x F 79	Yrs.			Mar 5,	1925	New	York	
	land		10a. State 10b. County	10c. City	, Town or Lo	ocation				1	Od. Inside City Limits	
	Mary 1 sh	tor	Maryland Montgo	nery	Silve	r Spr	ing				1 ☐ Yes 2 X No	
	r 28a	lrec	10e. Street and Number			10f. Zip	Code		10g. Citiz	en of What Cour	ntry?	
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Medical Examiner must be modified at	by Funeral Director	13816 Blair Ston	e Lane			20906		Uni	ted Sta	tes	
	r dea	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Dece	dent of Hispanic Origin? cify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	- 1-	 Race - Americ Bfack, White, 		
36	s afte	y Fi	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1 🗆 Yes	2₺ No Specify:			Specify:	white	
21215-0036	hour	ed t	15. Decedent's E		16a. Dece	dent's Usu	al Occupation		16b. Kin	d of Business/Inc		
15	n na	plet	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life.	kind of wo DO NOT u	ork done during most of wase retired)	vorking			,	
212	d with giene grante	Completed	12	College (1-401 54)	Но	memak	er			Own Hor	ne	
nd	should be filed with and Mental Hygiene. Is marked other ther eumatic event. In M	Be	17. Father's Name (First, Middle, Last					lame (First, Middle				
yla	ould b Ment arked	P	Jacob	Cohen			Anna			Shahon		
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. item 27 is marked other then "natural", or items 23e or 28a-f show other treumstic event. In Medical Examinar must be reciliated at		19a. Informant's Name/Relationship (1	62	S (Street and Number or		-			
	permit. Pages 1 and 3 Department of Health Importent: If item 27 eny injury or other tr		Irwin Carlen, h	usband 206. PI	ace of Dispo	sition (Na	r Stone Lan	Date		ation - City or To		
Baltimore,	Pages nent of I		1 ⊠ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special	Removal from State	emetery, crei	matory or o	al Gard. 12	/12/0/		y, Mary		
i iii	permit. Page Department o Importent: If eny injury or once.		21. Signature of Fureral Sance Line	_//						•	Lanu	
B	permit. Departr Importe eny inju		1 Janey 1	Josei	E 1	dward Ngi R	nd Address of Facility I Sagel Fune Rockville Pi	rai Direc ke. Rocks	ction ville	, Inc.	352	
	- 11		23a. Part 1 Enter the disease, or comshock, or heart failure. List only	plications that caused the death						, 120 200	Approximate Interval Between	
	Pnysician :		Immediate Cause (Final disease or condition	BLADDER CANO							Onset and Death	
	/Medical		resulting in death)	Due to (or as a consequ	ience of):						70	
	Examiner	L	Sequentially list conditions,	b								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ience or):					1		
	e be executed sician and burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	ience of):							
760,	The law requires that the death certificate be executed at the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	calE	(d								
68	death certificate b attending physic of for use as the b											
Вох	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal		□Ectopic p	regnancy		23	3d. Date of delive	•	
	e dea he ati	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	ath 5	Other (sp	pecify)			Month	Day Year	
P.0	that the death ned by the atter detached for u	Phy	Part ff. Other significant conditions	contributing to death but not resu	ulting in the u	nderhing	Squee given in Part I	23a Did t	obacco us	e contribute to th	e cause of death?	
ds,	uires tha signed d be det	d by	artin data organican contention	your bearing to doubt but not not		naony ing c	adoo garaan aa aa aa aa aa aa aa aa aa aa aa aa		Yes 2□		ably 4 XUnknown	
Records,	w requir been si should I	Completed						24a. Was	20	24h Were auto	psy findings available	
Re	sician: The law certificate has b irector, page 2 s	шč						autor	rmed?	prior to cor death?	npletion of cause of	
Vital	10 -	0	25. Was case referred to medical				26. Place of D	1 ☐ Yes leath (Check only o	2 XNo	1 🗆 Yes	2 L No	
\geq	Physician: this certifica ral director, p	To B	examiner? 1 □ Yes 2 🎇 No	Hospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 DC	Other			Other (Specify	()	
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 2	28c. Injury at Work?	28d. Describe				
Sio	Attendii death. ctor: A y the fu	catle	2 Accident investigation 3 Suicide 6 Could not be			М	1 Tes 2 No					
Division	l or Attendafter deatl Director:	Certification:	4 Homicide determined		me, farm, str ')	eet, factor	y, office	28f. Location (3		Number or Rura	l Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		29a. Certifier 1X Certifying Pl	nysician: To the best of my know	wledge deat	h occurred	at the time, date and pla	ce and due to the	cause/s) a	nd manner as st	ated	
	24 hi 24 hi e Fun etely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examinat and manner stated.	ion and/or in	vestigation	n, in my opinion, death oc	curred at the time,	date and p	place, and due to	the cause(s)	
	To the To the To the To the Complex co	Me	29b. Signature and title of certifier			29	c. License number		29d. Date	signed (Month,	Day, Year)	
			1 / sunce	M.1).			53/77		ECEM	BER 9, 2	2004	
-	3/1-		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print) J	OHN WALMAN	, M.D.	11	100-1	,20878	
				lice Con	Jek?	P	OHN WALMAN	OCFVI	1/4	UNIC		
	Sta Registi		31. Date filed (Month, Day, Year) NFC 14 20	32. Registrar's Signat	#	Spo	nks					

	1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H		ental Hygier	2004	4197
Dhysisi	1. Decedent's Name (First, M	iddle, Last)				2. Date of Death Month	ay Year	3. Time of Death
Physicia /Medic	al Young	Sook	Ch			December	12, 2004	2:35 a
Examin		200	r)		Location of Death		c. County of Death	
	Holy Cross H 5. Social Security Number		Age (In yrs. last birthday)	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth	Montgomer 9. Birtho	y lace (State or Foreign
Funeral Director	214 96 7024	1 □ M 2 🙀 F	94 Yrs.	Months Days	Hours Min.	Month, Day, Yea Nov. 10,		lace (State or Foreigi itry)
P.	Usual Residence of Deceden					107. 109		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If them 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, it is Marked to the traumatic event.	j Maryland Mon	ntgomery	Silver Sp				1	0d. Inside City Limits 1 ☐ Yes 2 No
r 28a	10e. Street and Number			10f. Zip Code	·	10g. (Citizen of What Cour	ntry?
th wit		enue			20902		USA	
r dea lems	901 Arcola Avenue 11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Americ Black, White,	an Indian, etc.
36 s afte	1 Never Married 2 □	If Yes, Give	X No	1 □ Yes No	Specify:		Specify: Asia	
hour tural	5 Javidowed 4 Divol	'ced Year or Dates dent's Education		dent's Usual Occup	ation	16h	Kind of Business/Inc	
in 72 n "na	(Specify only hi	ghest grade completed)	(Give	kind of work done of DO NOT use retired	during most of working	ng list.	TAILS OF EGGINGGENIA	330117
212 d with giene.	Elementary/Secondary (0-	2) College (1-4o	*	emaker			Own Home	9
Baltimore, Maryland 21215-0036 Dearlit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. mportant: if Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exert ance.	17. Father's Name (First, Mid	dle, Last)			18. Mother's Name	(First, Middle, Maide		
/lar	Unknow	wn.				Unknown		
Z sho and is mu	19a. Informant's Name/Relat	ionship (Type, Print)				I Route Number, City		
and and lealth m 27	Sook Wong Le	e / Daughter				ver Sprin		
Oroges 1	20a. Method of Disposition 1 ■ Burial 2 □ Cremat	ion 3 Removal from Stat	20b. Place of Dispo cemetery, cre	matory or other plac	(e)	ate 20c.	Location - City or To	wn, State
tant: Pa	`4 □Donation 5 □ Othe		Norbeck	Memorial		4/2004 01		
Bal Department Separtm	21. Signature of Funeral en	ce Ucensee		2. Name and Addres	птп	es Rinald:		
- 48264	23a. Part1. Enter the disease	or complications that could				Ave Silve	er Spring,	Md 20904 Approximate
	shock, or heart failure.	List only one cause on each	line.	ter the mode of dyn	g, such as cardiac o	respiratory arrest,		Interval Between Onset and Death
Pnysician /Medical	disease or condition resulting in death)	a. Pneumo						Days
Examiner		Due to (or a	as a consequence of):					
	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequence of):					
8760, rate be executed hysician and the burial-transit	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	1						
O, 1 exectan an an rial-tr	resulting in death) Last	Due to (or a	as a consequence of):					
X 68760, certificate be e. ding physician ise as the buria	Cal	d						
rtifica	W IF FEMALE:							
0 - 5	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 Yes 250 No 9 Unknown	I Live birth	2 Fetal death 3	⊒Ectopic pregnancy			23d. Date of delive Month	Day Year
O. Bo	1 Yes 25No	4☐ Pregnant 9☐ Unknown		Other (specify)			THO THE	Day
Records, P.O he law requires that the shas been signed by the ige 2 should be detached.		ditions contributing to death	but not resulting in the	inderlying cause giv	en in Part I	23e. Did tobacco	use contribute to the	e cause of death?
ords, requires t	ĝ		,			1 ☐ Yes		ably XXUnknown
v requ	Pulmonary To	ibercurosis				24a. Was an	24h Mara auta	nou findinan avadabl
Rec The law ite has b	Dementia					autopsy performed?	prior to cor death?	psy findings available apletion of cause of
/ tal n: Th	25. Was case referred to me	dical			og Blass of Basili	1 Yes XX	lo 1 □ Yes	¾CX No
of Vital of Vital Physician: 1 this certifica	examiner?	Hospital:	utient 2 ER/Outpatie	at 3D DOA Oth	er: 4 Nursing Hon	ne 5 Residence	6 □Other /Specifi	4)
O Phy	F	28a. Date of Ir				28d. Describe how in		//
Vision Attending If death. Sector: Attention by the fune	1 X Natural 5 Pe	restigation	Day Year) Injury		Yes 2□No			
Division i or Attending after death. Director: After		termined 28e. Place of l	Injury - At home, farm, st etc. (Specify)	reet, factory, office	2	28f. Location (Street a	and Number or Rura	l Route Number,
Di rs aft	Cer							
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	29a. Certifier 1₺ Cert	ifying Physician: To the besical Examiner: On the basis and manner	of examination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the cause ed at the time, dato a	(s) and manner as st nd place, and due to	ated. the cause(s)
thin 2 the	29b. Signature and title of ce		StateU.	29c. Licens	e number	29d. D	Date signed (Month, I	Day, Year)
H 3 H 8		HUIM-		D542		-	-12-20	
12	30. Name and address of per	son the completed cause of	f death (Item 23a) (Type	-	/ 1 /	12	12 00	
	Neeraj Chopra		Box 8319	1	urg, Mary	land 208	383	
Sta	31. Date filed (Month, Day, Y	'ear) 32. Degis	strar's Signature	Sporks				
Registr	ar DEC 1	4 2004	The same	apour				

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death	2
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	h
	Physici /Medi		Elizabeth Small Collins December 12 2004 10:00 A	М
4	Examir		4a. Fecility Name (If not institution, give street and number) Shady Grove Adventist Hospital 4b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery	
	Funeral Director		5. Social Security Number 218 16 0257 1 M 2 F 81 Yrs. 7. Age (In yrs. last birthday) 81 Yrs. 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8 March 14 1923 9. Birthplace (State or Fore Country) March 14 1923 Maryland	эign
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	nits
	Mary a-f sh	to		
	72 hours after death with the Maryland natural', or items 23a or 28a-f show after Examinat terroutiled at	al Direc	10e. Street and Number 10001 Watkins Road 10f. Zip Code 20882 10g. Citizen of What Country? United States	
9	after deat or Items ?	Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ 40 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
03	Jral', o	d by	3 □ Widowed 4 □ Divorced Specify: Specify: White	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Macdical Examiner runs Les notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Education (Give kind of work dorne during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Give kind of work dorne during most of working life. DO NOT use retired) Co-Owner Construction Co.	
	be filed ta! Hyg d other	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Maryland	2 should by and Menta is marked raumatic ex	ToE	Charles U. Small Mary Stang	
Mar	d2sh thanc t7 is n		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert W. Collins / Husband 10001 Watkins Road, Gaithersburg, Md. 20882	
ē,	permit. Pages 1 and 2 s Department of Health an Importent: if item 27 is any injury or other trau		20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State	
im			1/2 Burial 2 Cremation 3 Removal from State Neelsville Cem. 12/15/04 Neelsville, Md.	
Baltimore,	permit. Departi	21. Signature of Funeral Service Licensee Muriel H. Barber Funeral Home P. 0. Box 5038, Laytonsville, Md. 20882		
Г			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death	
Į.	Examiner		Due to (or as a consequence of):	
	rted	Examiner	Sequentially list conditions, if any, is a not a limit districtions. Due to for as a consequence of): Cause. Enter Underlying Cause (Disease or injury that initiated events) A UNIMONIA HERE TO CONTROL OF THE CONT	1175
,00	cate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	1)
8760,	icate b physic s the b	edical	d	
.O. Box (The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
<u>a</u>	quires that the de n signed by the uld be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANCLIZ, LUNG - 121 FM PNEW ON ELECTION 3 Probably 4 Unknown	wn
Records,	ne law requii has been s ge 2 should	Completed	24a. Was an autopsy findings availate prior to completion of cause of death?	ole if
Vital		e Co	1 Yes 2 No 1 Yes 2 No	
Ϋ́	Physicien: this certifice ral director,	ToB	25. Was case referred to medical systeminer? 1	87
n of	fter		27. Mannef of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 28c. Injury at Work?	
Division	vttend death ctor: A y the f	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined experiment of the determined state of the state	
Div	el or A s after il Dire	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To th withir To th comp	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
•	7		" Helly // Well y "07 20102 12/12/04	
	•		38 Name and address of person who contributed cause of death (Item 23a) (Type, Print) 10 A1212 JULEVIN, MN 10215, FEIZNWOOD Rd Bethes da, M	K
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	

	For State Registrar 1. Decedent's Name (First, Middle, La		partment of Health and ertificate of Death	Reg. No.	004 41973
Physician /Medical Examiner	Melvin	N. Carter	4b. City, Town, or Location of Der District Heigh	ath 4c.	2 2004 12:13 P
Funeral Director	5. Social Security Number 6. S 229-56-4847 Usual Residence of Decedent	7. Age (In yrs. last birthday 15 所 2 日 F 63 Yrs.		rs. 8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Fore Country) 9. Virginia
/z hours after death with the Maryland naturel; or items 23a or 28e-f show iteal Examitter must be notified at	10a. State 10b. County MD Prince G 10e. Street and Number 6923 Bank Run Ter			10g. Citiz	10d. Inside City Lim 1
perinit. Pages I and 2 should be filed within 72 hours after death with models of Health and Mental Hygiene. Departabilit if them 27 is marked other then "naturel; or items 23a any injury or other traumatic event, the Madical Examinational Longs. To Be Completed by Funeral I	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
z snould be filed within /z hours and Mantal Hygiene, and Mantal Hygiene, "aumatic event, the Madral Ex. To Be Completed by	(Specify only highest gri Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last	College (1-4or 5+) 1 yr Truc	e kind of work done during most of w DO NOT use retired) Lk Driver	orking Privame (First, Middle, Maiden)	
z should be in and Mental H Is marked out raumatic even	James N. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		A. Johnson	
rages I and nent of Health soft: If item 27 ary or other tr	Geraldine L. Cart 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	20b. Place of Disp cemetery, cre	Bank Run Terrace osition (Name of matory or other place) Crematory 12/	Date 20c. Loc	i hts, Maryland2 cation-City or Town, State cdale, Maryland
Department Pag Department Importent: any injury o	21. Signature of Funeral Service Licer	half	2. Name and Address of Facility J 7474 Landover Ro	.B. Jenkins : ad Landover,	Funeral Home
hysician /Medical xaminer	Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not er one cause on each line. HEPATIC FAILUF a. Due to (or as a consequence of):	E .	ac or respiratory arrest,	Approximate Interval Between Onset and Death
ician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): HEPATITIS - C Due to (or as a consequence of):	IOMA		
d by the attending physetached for use as the			□Ectopic pregnancy □ Other (specify)	23	8d. Date of delivery Month Day Year
been signed the should be detailed by PI	Part II. Other significant conditions of	contributing to death but not resulting in the u	nderlying cause given in Part I.		e contribute to the cause of death? No 3 ☐ Probably 4 ∰Unknow
	25. Was case referred to medical		00 00 - 10	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings availat prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
To la di	examiner? 1 Yes 2 Mo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		nt 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 kg Residence 6 28d. Describe how injury	
ours afte	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, stibuilding, etc. (Specify) ysician: To the best of my knowledge, deat		City or Town, State)	Number or Rural Route Number,
within 24 hou To the Fune completely fil	(Check only 2 Medical Examone) 29b. Signature and the of certifier	inner: On the basis of examination and/or in and manner stated.	29c. License number	urred at the time, date and p	lace, and due to the cause(s) signed (Month, Day, Year)
	· Much	all WWW	D2757	1 12	16/04

		1 - State Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of He tificate of D	ealth and Death		Reg. No.	004	41974
Physic /Med		Decedent's Name (First, Middle, Last)	Dorothy		COHEN		2. Date of De Month December	Day er 16	2004	3. Time of Death 1:00 A
Exam		4a. Facility Name (If not institution, give s Montgomery Village	Rehab. Cen		4b. City, Town, or Gaither	sburg	th	4c.	County of Death	ry
Funera Director			7. Age (In)	yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Cou	place (State or Foreign intry) aine
Aaryland f ahow	٥٢	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom		City, Town or Lo						10d. Inside City Limits
with the h or 28a-	Directo	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	intry?
portition (e.g., Mail yilding A.I.Z. 13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, the Medical Examinar mant be notified at	by Funeral	9920 Silver Brook 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		208 Nas Decedent of His f Yes, specify Cuban □ Yes 2 ₹ No		Specify Yes or No to Rican, etc.)	- 1	ed Stat 14. Race - Ameri Black, White Specify: W	ican Indian,
hin 72 hours an "natural", o	Completed b	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wo	rking	16b. Kir	nd of Business/In	
id be filed will entail Hygien ked other thus ic avent, the	Be Con	12 17. Father's Name (First, Middle, Last)		Но	omemaker	18. Mother's Na	me (First, Middle,		n Home Sumame)	
Should be not Ment in marked	To	Harry 19a. Informant's Name/Relationship (Type	Wasserman pe, Print)	19b. Mailir	ig Address (Street ar	nd Number or Ri	Sophie ural Route Numbe		danoye Town, State, Zi	p Code)
and 2 and 2 salth a n 27 is		Stephen Cohen, Son			Silver Br	ook Dri		vill	e, MD	20850
ages 1 and of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	_	sition (Name of natory or other place norial Par	· I	Date 17/04		cation - City or T	own, State
Definit. Pages permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service License 23a. Part1. East the disease, or complic	96	To	Name and Address rchinsky	of Facility Hebrew	Funeral	Home		20012
Physician /Medical		language of the disease, or compike shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Acute Myoc Due to (or as a con	ardial 1			c or respiratory ai	rrest,		Approximate Interval Between Onset and Death
Examiner up	Examiner	Sequentially list conditions, tary, leading to innertially cause. Enter Underlying Cause (Disease or injury that initiated events	Renal Fail Due to (or as a con Crohn's Di	ure sequence #						
oo rou, ificate be executed physician and as the burial-transit	edical	resulting in death) Last	Due to (or as a con	sequence of):						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	tF FEMALE: 23 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			2	3d. Date of deliv Month	ery Day Year
quires that an signed to and be deta	ρ	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	ndertying cause giver	n in Part I.				he cause of death?
The law requires to the law been signed to the second of t	Completed								24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of 2 No
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	on: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 □ Pending	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea.	2 ER/Outpatien 28b. Time of Injury	t 3 DOA Other	Nursing F	ath (Check only of Home 5 Residence 128d. Describe h	dence 6		(y)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attending completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, streecify)	M 1□Y	es 2 No	28f. Location (3 City or Tox			al Route Number,
tha Hospital nin 24 hours a the Funeral I	edical C	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my ler: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the time restigation, in my opi	e, date and place nion, death occu	e, and due to the curred at the time,	cause(s) a	and manner as s place, and due to	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier)		29c. License D 4	number 1102			signed (Month, mber 16	
(5)		30. Name and a ress of person who con Vinu Ganti, M.D.,				own, MD	20874			22.4
S Regis	tate trar	31. Date filed (Month, Day, Year) DFC 1 7 2004	32. Registrar's Si							

		1	For State of Marylan		artment of H rtificate of L		ental Hygier Reg. I	2004	41975
	ţ.		Decedent's Name (First, Middle, Last)				2. Date of Death	Year Veer	3. Time of Death
н	Physicia		Charlotte Elymara Carr				December	23 • 2004	8:45 A ^M
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
463	Examin	· .	College View Center		Frederic	k	F	rederick	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Birth (Month, Day, Yea	9. Birt	thplace (State or Foreign ountry)
	Funeral Director		219-01-9563 ¹ M ^{2□} F 89	Yrs.	Months Days	Hours Min.	March 8,	1915 Mar	yland
			Usual Residence of Decedent						Land to constitute
	ylan		10a. State 10b. County 10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
	Ma S	ō	Maryland Frederick Fred	erick					
	h the	ire	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
	th wil	aic	625 Schley Avenue		21702		USA		
	be filed within 72 hours after death with the Maryland Hygiene. de Hygiene. do ther than "natural", or itama 23a or 28a-f show dether than "natural", or itama 23a or 28a-f show avant, Ite Madical Examinating the notified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	or It	F	1 ☐ Never Married 2 💆 Married 1 ☐ Yes 2 💆 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify:	
8	ours iral',	d by	3 Widowed 4 Divorced Year or Dates:				10		ite
7	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of worki		. Kind of Business	industry
2	within ene. than "	mp	Elementary/Secondary (0-12) College (1-4or 5+)	self	DO 1407 USB 1611160	4)	ha	memaker	
7	e filed within al Hygiene. other than vant, it e M		0 17. Father's Name (First, Middle, Last)	Sell		18. Mother's Name	(First, Middle, Maid		
nc	be fi	Be	Thomas Daniel Oden			Mary Fran	202 7022		
Maryland 21215-0036	es 1 and 2 should be of Health and Mental (itam 27 is marked or rothar traumatic eve	၉	19a. Informant's Name/Relationship (Type, Print)	19h Maili			I Route Number, Cit	v or Town, State.	Zip Code)
<u>a</u>	12 st h and 7 Is n			4					1
	1 and 2 Health tam 27 othar tra		Warren Carr, husband 20a. Method of Disposition 20b. F		osition (Name of matory or other place		erick MD	21/02 Location - City or	Town, State
20	Pages nent of int: If its iry or o		1 X Burial 2 Cremation 3 Hemoval from State		matory or other plac et Cemete		/2004 Fre	doriole	Maruland
Ħ	rtmer rtant rtant njury		* 4 □Donation 5 □ Other (Specify) MT 21. Signature of Funeral Service Licepsee						uneral Home
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		Kyan M. Beige MO	0999 1	06 East C	Church Str	eet, Fred		D 21701
			23a. Part1. Enter the disease, or complications that caused the deat shock, of heart failure. List only one cause on each line.	h. Do not en	ter the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
1	Fnysician	4	Immediate Cause (Final disease or condition a. Atheroscler	otic H	eart Dise	ease			Years
	/Medical		resulting in death) Due to (or as a consec						
	Examiner		Sequentially list conditions, b.						
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	uence of):					
VII	and trans	Examine	that initiated events c.						
8760,	requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit		resulting in death) Last Due to (or as a consec	querice or).					
876	ate b hysic the b	Physician/Medical	d						_
9	death certification plants as the for use as the	Med	IF FEMALE:					201 5	
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant 1	al death 3	Ectopic pregnancy	у		23d. Date of de Month	Day Year
	the all	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4 ☐ Pregnant at time of c	leath 5	Other (specify) _				
P.0	that the deed by the detached	Phy	Part II. Other significant conditions contributing to death but not res	sulting in the	inderlying cause gr	ven in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
ŝ	res that signed to be det	by	Diabetes Mellitis Type II				1 ☐ Yes	2 □No 3 □ P	robably 4 XUnknown
Records,	v requir been s	Completed	Diabetes Mellicis Type II				04-146	045 14/222	uter a finding augustable
ec	aw 1s b	nple					24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
<u> </u>	Th ete pag	Con					1 ☐ Yes 2 🛣	No 1 ☐ Ye	s 2 No
Vital	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?		Oth		n Check onl one		-
)	y S	2	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐				me 5 Residence		ecify)
ū	ding P	on	27. Manner of Death 1 X Natural 5 □ Pending (Month, Day Year)	28b. Time Injury	Wo	rk? Yes 2 □No	200. Describe now	njury coodined	
sio	Attending r death. ector: After by the funer	cat	2 Accident investigation 3 Suicide 6 Could not be 389 Place of thium 4th			1103 2 1140	28f. Location (Stree	t and Number or F	Rumi Route Number
Division of	after d after d I Direct d in by	Certification:	4 Homicide 4 Homicide 4 Suicide 5 Suicide 4 Suicide 5 Suicide 6 Suicide		reet, ractory, onice		City or Town, S		1010 / 1010
	To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Ce	29a. Certifier 1 X Certifying Physician: To the best of my kn	nwladae daa	th occurred at the ti	me date and place	and due to the caus	e(s) and manner s	as stated.
	Hospital 24 hours a Funaral I	lica	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and magnet stated.	ation and/or i	nvestigation, in my	opinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	To the within 2 To tha complet	Medical	29b. Signature and title of certifier		29c. Licens	se number	29d.	Date signed (Mon	nth, Day, Year)
h	7. ¥ 7. 8		1 1 1 1 1	1	h DICL	28	Do	cember 23	3 2004
			30. Name and address of person who completed cause of death (Ite	m 23n\ /T	D1642	۷٥	рес	Jember 23	2004
	1	-	Casper Cline, MD, 300 West Nint			erick. MD	21701		
	- C1	ate		-4		, 110			
	Regist		31. Date filed (Month, Day, Year) - 32. egistrar's Sign	K A	new				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** December Elizabeth Campbell 16 2004 0550 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner SunBridge Care Center E1kton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☐ F Days Months Hours Yrs 147-12-5738
Usual Residence of Decedent Director April 19, 1921 New Jersey permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "netural", or items 23e or 23e-f show amportant: If Item 27 is marked other than "netural", or items 23e or 23e-f show any lutry or other traumatic event, the Medical Examine must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland | Cecil E1kton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 136 Ballantrae Drive 21921 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 TNo 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Homemaker In Her Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Ruth Clara James 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Barry Campbell/Son 136 Ballantrae Drive, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pennsauken, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Memorial Park 12/21/04 New Jersey 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) Atherosclerotio Heart disease /Medical Examiner Chrenic Obstructive Pulmonary dispase Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attanding Physician: The law requires that the death certificate be exectivitied. A hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician an completely filled in by the funeral director, page 2 should be detached for use as the bunish-try P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Abdomenal Aostie Aneurysm 1 ☐ Yes 2 ☐ No 3 ☐ Probabiy 4 ☐ Unknown Division of Vital Records. Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 214 1 Yes 2 No 1 🗆 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 10023322 12.15.2004 Herelider S 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) S-S, SACHDEV MD 118 North St Suc 118 North St Seite 3B Elkten MD21921. strar's Signature 31. Date filed (Month) State 2005 Registrar

			Tor State Registrar	State of Maryl	and / Depa <i>Ce</i>	artmen rtificate	t of H e <i>of L</i>	ealth a D <i>eath</i>	and M		giene Reg. No.	004	419	977
	hysici /Medio	_	Decedent's Name (First, Middle, Last, LOUIS POLLOCK COL							2. Date of De Month ECEMBE		2004		e of Death
	Examir		4a. Facility Name (If not institution, give FREDERICK MEMORIA	street and number) L HOSPITAL		4b. City, FRED		Location o	of Death	*		County of Dea		
Dir	ineral rector		5. Social Security Number 6. Security Number 216-76-2506	7. Age (In y	rs. last birthday) Yrs.	If Under Months	1 Year Days	Hours		8. Date of Birt (Month, Day May 22	h y, Year) 193		irthplace (Stal Country) irginia	
e Maryland	in participation	ctor	10a. State 10b. County Maryland Frederi		City, Town or Lo Frederi									e City Limits
th with th	23a or 28	Funeral Director	10e. Street and Number 387 Catoctin Av	enue		10f. Zip	Code 2 17 0	1				en of What C	Country?	
1215-0036 within 72 hours after death with the Maryland ene.	Importent: If item 27 is marked other then "naturel", or items 23s or 28e-f show eny injury or other treumetic event, the Medical Examinar must be notified at once.	by	11. Marital Status *\sum Never Married 2 \sum Married 3 \sum Widowed 4 \sum Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes ② No If Yes, Give Year or Dates:		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	city Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh Specify:Wh		l,
d 21215-0036 filed within 72 hours aff Hygiene.	r then "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e co <i>mpleted)</i> College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Never	k done d e retired)	uring most	of workin	g		d of Business	s/Industry	
Maryland 2 d 2 should be filed the and Mental Hygici	arked othe stic event,	To Be C	17. Father's Name (First, Middle, Last) Osgood McGi	11 Cousins	1					(First, Middle, tte Lou			7	4.5
e, Mary 1 and 2 sho Health and I	n 27 Is me er treume		19a. Informant's Name/Relationship (Ty Mrs. Michelle S.	Abell, Case M	an-er	2090 (01d	^{nd Number} Fa r m	ror Rumal Driv	Route Numbe	r, City or leric	Town, State,	Zip Code) 21702	
Baltimore, vermit. Pages 1 a Department of Hea	ent: If iten ury or oth		20a. Method of Disposition 1 □ Burial ② Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	p. Place of Dispo cemetery, crem mithsburg	natory or ot	ner place			nte 1004		ation - City or hsburg	r Town, State	
Baltimo	import eny inj once.		21. Signature of Funeral Saryice Lic 19		0255	Keen 106 E	ey a ast	nd Ba Churc	sforch St	d PA Fu	mera leric	1 Home	21701	
Pnys /Me	ician dical		23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Acute	,nterio							tion	Approxim Interval E Onset an	nate Between nd Death
Exan	niner	Examiner	Sequentially list conditions, if any Learning to furnediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons									48	hour
3760, ate be e.	physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a cons	equence of):									
Box 6	by the attending pritached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pred 1 □ Live birth 2 □ Fredant at time of the control of	etal death 3	Ectopic pre					23	d. Date of de Month	livery Day	Year
rds, P	signed d be de	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the ur	derlying ca	use giver	n in Part I.					o the cause of	
FRe tav	certificate has been rector, page 2 shoul	e Compieted	25. Was case referred to medical								ned? 2 □ N o	24b. Were au prior to death?	utopsy finding completion of	s available cause of
Phys Of	inis al dii	ToB	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatient	-	Other	4 Nurs	sing Home	Check only on	ence 6[cify)	
E 00 3	5 5	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	28b. Time of Injury	М		es 2 🗍 N	0	d. Describe ho				
DIVISIO pitel or Attendi	alled in by		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify) 					f. Location (St City or Town	n, State)			umber,
To the Hospitel o	completely f	Medicai	one)	ician: To the best of my k er: On the basis of exami and manner stated.	nowledge, death nation and/or inv	estigation, i	n my opii	nion, death	place, an occurred	at the time, da	ate and pl	lace, and due	to the cause	
Towith	01	Σ	29b. Signature and title of certifier	ortura	ems		License i		82				h, Day, Year)	
	5		20(1.00	kouski i	M 3	9093	Ri	dque f	Pueld	Dive	i Fre	deri	le m	d
R	Stat legistra	· -	31. Date filed (Month, Day, Year)	32. Francis Sig	nature K	alls								

	1 - For Registrar Certificate of Death	Mental Hygiene Reg. No. 2004 41
hysician	Decedent's Name (First, Middle, Last) MARY FRANCES CARTER	2. Date of Death Month Day Year, 3. Time of
/Medical	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	12 - 27 - 04 \(\times \) th 4c. County of Death
xaminer	ST. CATHERINE'S NURSING CENTER EMMITSBURG	FREDERICK
neral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	
ctor	217-07-3442 10 20 99 Yrs. 99 Yrs.	09/08/1905 BALTIMORE,
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside Cit
ō	MD FREDERICK EMMITSBURG	1ሺ Yes
Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
a D	331 S. SETON AVE. 21727	U. S. A.
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14 Marital Status) 15. Was Decedent of Hispanic Origin? (Sp. 15 Marital Status)	Specify Yes or No- to Rican, etc.) 14. Race - American Indian, Black, White, etc.
by FL	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year, or Dates:	Specify: WHITE
	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Give kind of work done during most of work life. DO NOT use retired)	rking
E O	6 SEAMSTRESS	DRESS MAKING
Be	17. Father's Name (First, Middle, Last) 18. Mother's Nam	me (First, Middle, Maiden Surname)
2		OINETTE (UNKNOWN)
		ural Route Number, City or Town, State, Zip Code)
		Date 20c. Location - City or Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	
		SKILES FUNERAL HOME
	1/4.//	EMMITSBURG, MD. 21727-0427
dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Due to for as a consequence of): Due to for as a consequence of): d.	oscula Aisen 20 y 30 y
Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day 'Y
y PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of d
edt	Multi Infact Dementia	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐U
omple		24a. Was an autopsy performed? 24b. Were autopsy findings a prior to completion of codeath? 1 ☐ Yes 2 ☐ No
Be	examiner?	ath (Check only one)
	1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
ြို	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Sec. Injury at Work? 1 X Natural 5 Pending	28d. Describe how injury occurred
	M 1 Vac 21 No	
	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number
	2 Accident investigation M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Num City or Town, State)
Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	e, and due to the cause(s) and manner as stated.
	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	e, and due to the cause(s) and manner as stated.
edical Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D18705	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
edical Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (check only one) 29b. Signature and title of certifier 29c. License number	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) DECEMBER 27, 2004
edical Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D18705 30. Name and address of person who completed cause of death (Item 23a) (Type-Print)	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) DECEMBER 27, 2004

		1_ For Amend Items	State of Maryland 23a per Dr., G	d / Department of H 839 OI /04/2004d	ealth and Menta	al Hygiene	2004	41970
Physi		1. Decedent's Name (First, Middle, La		Continuate of E	2. Da	Reg. No.		3. Time of Death
/Med Exam	iner	4a. Fecility Name (If not institution, giv W. V) May (A) 5. Social Security Number	d Medical C	Months Davs	Location of Death MUYL If Under 24 Hrs. 8. Da Hours Min. Mi	te of Birth	County of Death BALTI 9. Birthpl Coun	MORE lace (State or Foreign
Directo	r	Usual Residence of Decedent 10a. State 10b. County	13	Yrs.	√A.	N. 6,19	31 YOR	Od. Inside City Limits
h the Mary r 28a-f ah	Director	PA YORK 10e. Street and Number		ORK 10f. Zip Code		10g. Citi	izen of What Coun	1 □ Yes 2 No
I.Z. I.D-UUJO within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ahow than "maturel" and the multiple milliple at	Funeral D	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Y		14. Race - Americ Black, White, e	
hours afte	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Xes 2 No Xes, Give Year or Dates:	1 Yes 2 No	Specify:	16b. Ki	Specify: WH	
III G Z IZ IS-0030 be filed within 72 hours after death with the Marylan ital Hygiene. Indoorber than "naturel", or floms 23a or 28a-f ahow avant, the Modical Exercities in the indilined at	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done d life. DO NOT use retired)	uring most of working	4	ORK TAPE	•
INGLYIGHTO A Id 2 should be filed the and Mental Hygic 27 is marked other traumetic avent, II	To Be (FFARO		18. Mother's Name (First	CAPI	TANO	
E, INGI 1 and 2 sh Health and 6m 27 is m ther traum		19a. Informant's Name/Relationship (NICKEY R. CUFFAR 20a. Method of Disposition	0 - SPOUSE	19b. Mailing Address (Street a 945 S. Rollace of Disposition (Name of	TAL ST,	YORK,	(11)	402
DELILIMOTE, MATYING permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other traumetic.	once.	1 Burial 2 Cremation 3 4 Donation 5 9ther (Special 21. Signature of Legisla Septical 1.	Removal from State Hei	emetery, crematory or other place LYSAVICUL CEM DST1 22. Name and Addres	ETER 200	5, 40	KK, VA	17402 NERAL HO
icate be executed Wedicate by Examine physician and sthe burial-transit	icai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence	sophageal Cance of Respiratory Dis	er			Approximate Interval Between Onset and Death
death certif	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy			23d. Date of delive Month	Day Year
The law requires that the law been signed by the lage 2 should be detached.		Part II. Other significant conditions of	contributing to death but not resu	ulting in the underlying cause give	on in Part I. 2	1.7	se contribute to th	ne cause of death? ably 4 Unknown
	Completed					ta. Was an autopsy performed? ☐ Yes 2 No	prior to con death?	psy findings available impletion of cause of
ysiclen: The is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital: W	Othe	26. Place of Death (Che			
Phys this rat dir	٢.	1 Yes 2 No 27. Manner of Death	1 Inpatient 2	ER/Outpatient 3 DOA Other 28b. Time of 28c. Injury	A Nursing Home 5	Residence escribe how injur		y)
or Attending Physicien: after death. Director: After this certific in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	O CO. Disco of laive. At he	Injury Work M 1 1	/es 2 □ No 28f. Lo		d Number or Rura	l Route Number,
To the Hospital or Attenwihin 24 hours after deal To the Funerel Director: completely filled in by the	Medical Cerl	29a. Certifier 1 Certifying Pl	nysician: To the best of my knominer: On the basis of examination	wledge, death occurred at the tim tion and/or investigation, in my op	e, date and place, and du	e to the cause(s)	and manner as st	ated. the cause(s)
To the within 2 To the complete	Med	29b. Signature and title of certifier	and manner stated. Uma MD	29c. License	number 1176435	29d. Dat	te signed (Month, I	Day, Year)
15		30. Name and address of person who	completed cause of death (Item Ullo N 25	23a) (Type, Print)		Balto	uld 2	21230
Sec.	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				

			For State Registrar	State of Maryland		rtment of Healt		ntal Hygie	2004	41980
	Physici		1. Decedent's Name (First, Middle, Last	· F D	SOM		(X)	Date of Death Month	Pag 2004	3. Time of Death
	/Medic Examir Funeral		4a. Facility Name (If not institution, give Doctors Comm 4 5. Social Security Number 6. S	estreet and number) in ty Hospita ox 7. Age (In yrs. las	/		ion of Death	Date of Birth	4c County of Death	Reorges place (State or Foreign
	Director	_	Usual Residence of Decedent 10a. State 10b County	a l	Yrs.	11	rs Min.	Month, Day, Ye	1947 Was	hungton DC 10d. Inside City Limits
	with the Ma 3a or 28a-f	I Director	10e. Street and Number 10714 Fairward	rieorges xt Road	Hy	10f. Zip Code	F4	10g.	Citizen of What Cou	1 ∰Yes 2 □ No intry?
920	72 hours after death with the Maryland naturel', or Itams 23a or 28e-f ehow Jisal Exacilier roust by recified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Yes, specify Cuban, Mex	Origin? (Specify tican, Puerto Rica	Yes or No- an, etc.)	14. Race - Ameri Black, White Specify:	
21215-0036	within ane. than "	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give F	ent's Usual Occupation kind of work done during in OO NOT use retired)	11	16b	Dist. G	ndustry vern ment
Maryland	Mer Merke Marke	To Be	17. Father's Name (First, Middle, Last) Tohn Black 100 laterment's Name (Relationship (kstone	10h Mailia	/	Puby	Wash	hington	0.41
	1 an Heall am 2 thar		19a. Informant's Name/Relationship (1) Lauten Deutly 20a. Method of Disposition 1 @Burial 2 Cremation 3 C	(<i>)</i> /5/er/	Hyge e of Dispos	g Address (Street and Nu f Control of sition (Name of atory or other place)	Date	9 nd 200	20784 Location - City or T	own, State
Baltimore	permit. Pages Department of I Important: If it any injury or o		4 □ Donation 5 □ Other (Specification 5 □ Oth	Herry	mon	Mame and Address of Fa			Jervic	e
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Termin al f	3 reas		as cardiac or res	spiratory arrest,	shin gton,	Approximate Interval Between Onset and Death Unknown
8760,	sate be executed oblysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent of the consequent						
O. Box 6	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deatl	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not resultin	ng in the un	derlying cause given in Pa	art I.	23e. Did tobacc	co use contribute to t	
of Vital Records,	The law ate has b page 2 sl	Completed						24a. Was an autopsy performed 1 Yes 2 4	? prior to co	ppsy findings available impletion of cause of 2 No
Vit	Physician; This certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER	VOutpatient	Othor	lace of Death (Ch		6 ☐Other (Specia	(v)
	ding h. After fune	atlon; T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28	Bb. Time of Injury	28c. Injury at Work? M 1 \(\subseteq \text{Yes} \) 2	28d.	Describe how in		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	i de de ce	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)				City or Town, St		
	tha Hos nin 24 h tha Fur npletely	Medical	one)	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death n and/or inve	estigation, in my opinion,	death occurred at	t the time, date a	and place, and due to	the cause(s)
Ĭ.	Mit To To	~	29b. Signature and title of certifier	m MA		29c. License numb		29d.	Date signed (Month,	•
	(m)		30. Name and address of person who	/ 1.13	3a) (Ture 5	D434	46		12.19.0	4
	(1)		ROINTAN FARAH				suit 3-4	Siliensa	Wind HA 2	0902
	Sta Registr	100	31. Date filed (Month, Day, Year)	32 Registrar's Signature	۵				5.1102	
	Registi	ar 	DEC 2 1 200	Blocker &	Goal	W.				

			For Stete Registrer	State of M	laryland / Depa <i>Ce</i>	artment of		and Mental I	Hygiene Reg. N	004	41981
-	Di-	s	1. Decedent's Name (First, Middle, L.	ast)				2. Date of	f Death	V.	3. Time of Death
	Physic /Medi		Inez	Day		9		Month DECEN	n 6 61	7.2004	7:10,AM
	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town	n, or Location of	of Death		ounty of Death	
		6	Doctors Communi 5. Social Security Number 6.	ty Hospita	1 (In use last historia)	Lanha If Under 1 Ye		24 Hrs. Lo. Data		nce Geo	
	Funeral Director		579-12-6236 Usuel Residence of Decedent	1□ M 2□ x F	87 Yrs.	Months Da			Day, Year) 27 17		place (State or Foreign ntry)
	/land		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	r 28a-f show	tor	D.C.		Washing	ton					1 X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show t⊤ust be nettined at	Director	10e. Street and Number			10f. Zip Cod	e		10g. Citizer	n of What Cour	ntry?
	ath wi		4325 Dubois Plac	e S.E.		200	019		US	SA	
36	aftar or Ite	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☑ 1		gin? (Specify Yes o , Puerto Rican, etc.		Race - Americ Black, White, Decify: Black	etc.
Maryland 21215-0036	72 hours "natural",		15. Decedent's 8	ducation	16a. Dece	dent's Usual Oc	cupation			of Business/Inc	
215	c * @	Completed	(Specify only highest gas Elementary/Secondary (0-12)	ade completed) College (1-4or	(Give	kind of work do DO NOT use rei	ne durina most	of working	1007,1112		,
21		Con	12th			ctical	Nurse		St. I	Elizabe	ths HOsp.
nd	be filac ntal Hyg ad otha event,	Be	17. Father's Name (First, Middle, Las	t)				r's Name (First, Mid		ımame)	
<u>≯</u>	should be nd Mental marked umatic ev	은	John H. Miles					isa Bost			
Mai	12 sho h and 7 Is mu trauma		19a. Informant's Name/Relationship					r or Rural Route Nu			Code)
	as 1 and 2 should of Health and Men fitem 27 Is marker rother traumatic		Royce A. Day/Son 20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Upper Ma		MD • tion - City or To	wn State
Baltimore,	Paga: nent o ant: If ury or		1 ABurial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Spec		Ft. LInce	natory or other p	place)	2-22-04	Brent	wood, M	ſd.
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	hall				Marshal N.W. Wash			
	/Medical cigan and purial-transit purial-transit	Examiner	23a. Pan. Enter the disease, or construction heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to for as c.	ine. Lhrn Vas C a consequence of: a consequence of: A seconsequence of:	ular	Ac		-		Approximate Interval Between Onset and Death
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rds, P	sign d ba	by	Part II. Other significent conditions	contributing to death t	out not resulting in the u	nderlying cause	given in Part I.		id tobacco use		e cause of death?
Il Records,	Thalaw ate has b page 2 st	Completed						24a. W a p	utopsy erformed?	4b. Were autop prior to con death? 1 \(\sum \text{Yes}\)	osy findings available npletion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Magaital				of Death Check or			
of Vital	Physician: this certific al director,	2	1 ☐ Yes 2 ☐ No 27. Mane of Death	Hospital:		t 3 DOA	Other: 4 ☐ Nur	sing Home 5 R)
Division	ding J. Aftar funei	catlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) 28b. Time of Injury	28c. In V M 1	liury at Vork? □ Yes 2 □ N		be how injury or	ccurred	
Divi	ital or Att irs after di ral Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	building, e	jury - At home, farm, stri tc. (Specity)			City or	n (Street and N Town, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	nysicien: To the best miner: On the basis o and manner st	of my knowledge, death of examination and/or invated.	occurred at the restigation, in m	time, date and y opinion, deat	place, and due to the control occurred at the time	he cause(s) and ne, date and pla	d manner as sta ce, and due to	ated. the cause(s)
)	To To		29b. Signature and title of certifier AL	Amya	ek. MO	\mathcal{L}	0005	9993	29d. Date si	gned (Month, E	Pey, Year)
R_	(4)		30. Name and address of person who			11/1/91	INSTRE	ET SUITE	= 35%	LAUKEL	MS Golog
:	Sta Registr		31. Date filed (Month, Day, Year) DEC 2 1 2004	2. Registr	ar's Signature	W					

	للي	1 - Stete Railerto Telem 25 per me 3341 Certificate (1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physicia /Medic		Geneva B. Dziekan		December	Day Year 16, 200	
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Tow	n, or Location of Death		4c. County of De	
			apolis		Anne Ar	
Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 \square F 7. Age (In yrs. last birthday) 1f Under 1 Yr Months Da	ear If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 29,	Year) 9. 8 1928 T	hirthplace (State or Foreign Country) EXAS
D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ehov	<u>ا</u> م					1 (X) Yes 2 ☐ No
the N 28e-1	Director	MD Prince George's Bowie 10e. Street and Number 10ft. Zip Coc	le	10	g. Citizen of What (Country?
3a or		12413 Rustic Hill Drive	20715		USA	
deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent If Yes, specify (If Yes,	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - An Black, Wh	merican Indian,
be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. Ad other than "netural", or Items 23a or 28e-f ehow event, tre Medical Evaniral nual be notified at	by Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 N		, mount, oto.,	Specify: W	
2 hou		15. Decedent's Education 16a. Decedent's Usual Oc	cupation	1	6b. Kind of Busines	
within 7 ene. than 'n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	*	King		
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be fill	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, M.	aiden Sumame)	
s 1 and 2 should be f Health and Mental item 27 is marked o other treumatic eve	၉	Erwin Drury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Str.)	Willy L		City or Town State	Zin Code)
and 2 seath an and 2 seath an 27 is ner treum	5 3	Andrew E. Dziekan / spouse 12413 Rustic				0715
of Health if Health item 27 i	99	20a. Method of Disposition 20b. Place of Disposition (Name o	1		0c. Location - City	
0 0		1 □XBurial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) MD. Veterans Cem		1-2004	Cheltenha	m, MD.
permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Ac	dress of Facility Be	all Funer	al Home	
₹0 = € Ø			Crain Hwy.	Bowie,		715
		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
nysician /Medical	ř i	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	rach Ir	idench	<u> </u>	-
Examiner		Due to (or as a consequence of): Se otic Shock				
	ie.	Sequentially list conditions, Tany, leading to immediate Due to (or as a consequence of):			- 100 M	
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ate b thysic the bi	dical	d. ====================================	CERTIFICATIO	PROVENDI		
entific ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy	CLITT	•	1	
leath certifica attending ph I for use as ti	Physician/Med	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnar			23d. Date of d Month	elivery Day Year
t the de by the tached	ysic	1 ☐ Yes 2 ☑ HNO 9 ☐ Unknown 9 ☐ Unknown	/	•		
de de		Part II. Other significent conditions contributing to death but not resulting in the underlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
w requires been sign should be	g pa	End Stage Renal Pisease		1 ☐ Yes	2 □ No 3 □ !	Probably 4 Dunknown
aw requisits been 2 should	Completed by	3		24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
	mo;			perform	ed? death? Se No 1 ☐ Ye	es 2 No
ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one,)	
Physician: this certific ral director,	2	1 Yes 2 Hospital: 1 patient 2 ER/Outpatient 3 DOA	to the same of the		ce 6 □Other (Sp	pecify)
ling After fune	io.	1 Natural 5 Pending (Month, Day Year) Injury	njury at Work? 1 □ Yes 2 □ No	28d. Describe how	v injury occurred	
or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, off		28f. Location (Stre	et and Number or I	Rural Route Number,
i Site	Certification:	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
Hospitel 24 hours a Funeral I tely filled		29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the (check only 2 Medical Examiner: On the basis of examination and/or investigation, in n	e time, date and place,	and due to the cau	use(s) and manner	as stated.
To the Hos within 24 h To the Fur completely	Medical	one) and manner stated.				
Vith Con	2		ense number		d. Date signed (Moi	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOW ARD YOUNG MD Anne Arum	0005829		12/16/	01(
7.	-					

ORIGINAL

			1- For State of Registrar	of Maryland		artment of F rtificate of		Mental Hygie	2004	41983
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Elizabeth J	ane Dean				2. Date of Death Month Decembe	Day Year r 18, 200	3. Time of Death 4 6:00 A M
×	Examir		4a. Facility Name (If not institution, give street and nu 7804 Hanover Parkway #2	04		Greent		th	4c. County of Dead Prince Ge	orge's
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 XF Usual Residence of Decedent	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bin (997) 9. Bin (Co	hplace (State or Foreign buntry) st Virginia
	the Marylan 28a-f show otified at	Director	Maryland Prince George's		Town or Lo	Lt				10d. Inside City Limits 1 X Yes 2 ☐ No
	s within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	Funeral Dir	7804 Hanover Parkway #20	edent Ever in U.S.	. 13.	10f. Zip Code 20770 Was Decedent of He f Yes, specify Cuba			Citizen of What Conited Star 14. Race - Ame Black, White	tes
5-0036	72 hours aft natural', or	by	1 Never Married 2 Married 1 Yes 3 XWidowed 4 Divorced If Yes, Gir 15. Decedent's Education (Specify only highest grade completed)	/e ates:	16a. Dece	l ☐ Yes 2 🗓 No	Specify:	16	Specify: W	
Maryland 21215-0036	iled within dygiene. ther than "	Completed	Elementary/Secondary (0-12) College (12) 12 17. Father's Name (First, Middle, Last)	1-4or 5+)		kind of work done DO NOT use retired 11 Sales	Clerk	me (First, Middle, Ma	Gift Shop)
arylan	ed at a	To Be	Odie Snyder 19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	Minnie	Phillips ural Route Number, C		lip Code)
	Health Health tam 27 other to		Lynn Dean - Son 20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from	20b. Plac	17428 ce of Disponetery, cren	Evange1 sition (Name of patory or other place	ine Lane	2 ³ 2004 2004	Maryland 2	20832 Town, State
Baltimore,	permit. Pages Department of in pertant: If i any injury or on a.		*4 □ Donation 5 □ Other (Specify) 21. Signature of 5 dineral Service Licensee	Upsh	22	unty Memo	ss of Facility loleswort	h P.A. Fur	neral Home	West Virgin
	Medical Examiner Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Least Observed that initiated events c.	aused the death. ach line. 1 Carcino (or as a consequer or as a consequer	Do not enter Dma nce of):	or the mode of dyin	ge ROAG,	Damascus,	Maryland	Approximate interval Between Onset and Death 5 months
P.O. Box 68760,	death certif e attending id for use a	Physician/Medical	1		éath 3□ th 5□	Ectopic pregnancy Other (specify)			23d. Date of delifi Month	very Day Year
Ś	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to de	eath but not resulting	ng in the un	derlying cause give	en in Part I.	23e. Did tobac	co use contribute to 2 XNo 3 ☐ Pro	the cause of death?
Vital Record		e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 ☐ Yes 2 🗶	prior to or death?	opsy findings available ompletion of cause of
Division of Vi	utending Physical death.	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Bb. Time of Injury		er: 4 🗌 Nursing H	ome 5 X Residence 28d. Describe how in	njury occurred	
ā	To the Hospital or Attanwithin 24 hours after deating to the Funeral Director: completely filled in by the	edical Certi	29a. Certifier (Check only) 29 Medical Examiner: On the ba	ng, etc. (Specify) best of my knowle	adge, death	occurred at the tim	ne, date and place pinion, death occu	City or Town, Si	(s) and manner as	risted
)	To the within 2 To the comple	Med	29b. Signature and title of certifier May 124	iner stated.	M	29c. License		29d.	Date signed (Month,	
	3		30. Name and address of person who completed caus Marcia L. Will, MD, 7525	Greenway	v Cent	rint)				20770
	Sta Registr		31. Date filed (Month, Day, Year) 32. R	egistrar's Signatur	°C 2 1	2004	Come 1	of front	P	

			1 - State of Ma	ryland / Depa <i>Cei</i>	artment of H tificate of I	lealth and I Death		ene2 0 0 4	41984
	0		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medic		Edward Davis				Month	Day Year 12, 2004	7.30 a M
>	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Deal	
Н			Shady Grove Adventist Nursir	ng& Rehab.	Rockvi	ille		Montgon	erv
	Funeral			(In yrs. last birthday)	If Under 1 Year Months Davs	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
н	Director		231-01-8465 1 [™] 2□F	86 Yrs.	Months Days	Hours Min.	(Month, Day, May 2, 1	0.00	th Carolina
	pu »		Usual Residence of Decedent 10a. State 10b. County	10- 01- 7-					
	anyta shor	-	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	8e-f	Director	Maryland Montgomery	Burtonsy					1 ☐ Yes 2 € No
	with t		10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23	Funeral	3322 Tapestry Circle		20866			USA	
	ltam Itam	'n.	11. Marital Status 12. Was Decedent Ev Armed Forces?	l ti	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	within 72 hours after death with the Maryland ene. Then "naturel", or Itams 23a or 28e-f show the Mical Exercities or settle mailined	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ X	1	☐ Yes 🏖 No	Specify:		Specify: Bla	ack
2-0036	tura stura	ed	15. Decedent's Education	16a Deced	ent's Usual Occupa	ation		6b. Kind of Business/	Industra
7	n "ng	plet	(Specify only highest grade completed)	(Give	kind of work done of OO NOT use retired,	luring most of world	king	DO. KING OF BUSINESS	Modstry
2	d with giene r the	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	,	eman			Moving Con	npany
פַ	be filed within 72 hours after death with the Marylan at Hygiene. Ide thy then. Insturel', or Itams 23a or 28e-f show evant, It s Marical Extrains are ast be ruffled a	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Ma		1 3
Maryland 2121	henta henta rkad rkad tic ev	To B	William Thomas Davis			Mini He	enry		
az	shot and N s ma uma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number or Rui	al Route Number, (City or Town, State, Z	lip Code)
Σ	alth alth 27 is ar tra		Brenda Lehmann-Taffe/Daughte					ille, MD 2	
Ze	itam	Ш	20a. Method of Disposition	20b. Place of Dispos	sition (Name of natory or other place		Date 20	C. Location - City or	
Ĕ	Page Int: H		1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Burtons	ville Uni eterv	on Decem	ber 18 004 B	urtonsvill	e, Maryland
altimore,	permit. Pages 1 and 2 should be filed with poperturent of Health and Mental Hygen Important: If item 27 is marked other than any injury or other traumatic evant. Its once.	- 19	21. Signature of Funeral Service Licensee				Funeral		.c, naryrana
m	88 1 8 8		Kechard I Hales	50	O Univers	sity Blvd	l, W, Sil	ver Sprinc	, MD 20901
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	e death. Do not ente					Approximate
	Physician		Immediate Cause /Final	Post Major	Ctroles				Interval Between Onset and Death
	/Medical		resulting in death)	consequence of):	Stroke				
H	Examiner		Sequentially list conditions b						
	п =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):		-			
	cuted	Examiner	that initiated events						
Ö,	e exe ian a urial-		resulting in death) Last Due to (or as a d	consequence of):					
09/80	ficate be executed ip physician and is the burial-transit	edicai	d						
		Med	IF FEMALE:		77)				
ХOЯ	death certif e attending d for use as	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of deli	,
	0 0 0	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tin 9 ☐ Unknown 9 ☐ Unknown	ne of death 5	Other (specify)			Month	Day Year
ī.	that the de led by the a detached f	Ph)		and an explain of a state of					
က်	Se Jo	by	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause give	n in Part I.		cco use contribute to	
ecords,	w requir been si should l	eted					1 Yes	2 No 31 Pro	bably 4 Unknown
ပ္	15 a	ompieted		· <u></u>			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
= =	Thate ate	Co					performe 1 ☐ Yes 2 €	d? death?	
Vital	ding Physician: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?				(Check only one)		_
0	hys this	ပ္	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient			4 Avursing no	me 5 Residenc	e 6 Other (Spec	ify)
_	ding Phys n. After this funeral di	on:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injury Work		28d. Describe how	injury occurred	
VISION	tend death tor:	icat	2 Accident investigation 3 Suicide 6 Could not be			es 2 □No			
\leq	or Ai	ertification;	4 Homicide determined 28e. Place of Injury building, etc. (At home, farm, stre Specify) 	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
_	pital urs a arel l	O	20-0-170-						
	Hos 24 hc Fun stely	edicai	29a. Certifier (Check only one) 1© Certifying Physicien: To the best of real manner state.	(amination and/or inve	occurred at the time estigation, in my opi	e, date and place, nion, death occurr	and due to the caus ed at the time, date	se(s) and manner as : and place, and due !	stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signature and the of certifier	J.	29c. License			. Date signed (Month,	
			Wat The		D58			ember 13,	
	13		30. Name and address of person who completed cause of deat	h (Itam 32a) (Time 5			Dec		2004
			Shahryar Davari, M.D. 1522			Suit o	200 B-1		20050
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's	Signature 6	Sports	, surce	ZUO, KOCK	ville, MD	20850
	Registra		31. Date filed (Month, Day, Year) NFC. 1 4 2004 32. Registrar's	The Popular	pours				

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was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıl death 3□	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
				en in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
hronic Obstruct	tive Pulmonary	Diseas	e		D {□ Yes	s 2 No 3 Prob	ably 4 Unknown
					24a. Was an	24b. Were autor	osy findings available
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Was case referred to medical				26 Place of Death			2⊔ No
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	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury	at			/
Accident investigation	on	77					
d at a min a	d 28e. Place of injury - At no		eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rurai State)	Route Number,
Certifier Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my kno aminer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as sta te and place, and due to	ated. the cause(s)
Signature and title of certifier	/	1	29c. License	number	296	d. Date signed (Month, L	Day, Year)
> Wichin	son J. N.	inala	D45	285		December	13, 2004
	1111	220) (Tuno 1	Print)				
	Was case referred to medical examiner? Yes 2X No Manner of Death XX Natural 5 Pending investigate 6 Could not determine Certifier (Check only one) Signature and title of certifier	Nas case referred to medical examiner? Yes 2 No Hospital: 1 Image: 1 Image: 2 Image: 2 Image: 3 Image: 4	Nas case referred to medical examiner? Yes 2X No Hospital: 1 Impatient 2 ER/Outpatient Hospital: 1 Impatient 2 ER/Outpatient Hospital: 1 Impatient 2 ER/Outpatient Hospital: 1 Impatient 2 ER/Outpatient Manner of Death 28a. Date of Injury (Month, Day Year) Impatient 2 ER/Outpatient 28b. Time of Injury 28b. Time of Injury Month, Day Year) 28b. Time of Injury 28c. Place of Injury - At home, farm, street Walded 18 18 18 18 28c. Place of Injury - At home, farm, street 28c. Place of Injur	Nas case referred to medical examiner? Nas case referred to medical examiner? Namer of Death Selection investigation and color investigation and manner stated. Certifier (Check only one) Signature and title of certifier Was case referred to medical examiner: Observed to medical examiner: On the basis of examination and/or investigation, in my operation and manner stated. D45 Was case referred to medical examiner: 1 2 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 ER/Outpatient 3 Input (Month, Day Year) 2 Input (Mo	Was case referred to medical examiner? Yes 2X No	Armonic Obstructive Pulmonary Disease 24a. Was a autopsy perform 1 26. Place of Death (Check only one Armonic of Death (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Month, Day Year) 28c. Injury at Work? Month, Day Year) 28c. Injury at Work? Month, Day Year) 28d. Describe how the determined of Could not be determined at the time, date and place, and due to the cand manner stated. 28d. Describe how the Course of Death (Check only one Arm, street, factory, office) 28d. Location (Str. City or Town, Other and Month of Death (Check only one) 28d. Describe how the Could not be determined at the time, date and place, and due to the cand place, and due to the cand manner stated. 29c. License number D45285	hronic Obstructive Pulmonary Disease 24a. Was an autopsy performed? 1 Yes 2 No 3 Prob 24a. Was an autopsy performed? 1 Yes 2 No No Was case referred to medical eath? Yes 2 No Was case referred to medical eath? Yes 2 No Was case referred to medical eath? Yes 2 No Was case referred to medical performed? Yes 2 No Was case referred to medical eath? Yes 2 No Was case referred to medical performed? Yes 2 No Work? Yes 2 No Work? Yes 2 No Yes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended 12-21-04/item #9/wichd/filianate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day LENA DWNING 2004 December 14 10:55 AM[™] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 XF Hours Yrs. 219-44-17D Usual Residence of Decedent N.Y. Director 12-28 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director ALLEN 1 CDMICC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 810 USA FOBOX Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No þ BLACK 3 ☐ Widowed 4 ☐ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) WORKER 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oths any judury or other traumests. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be DWNING WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pork ALLEN MD. POBOX 1082 SHIRLEY SISTER 280 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL ' 4 □ Donation 5 □ Other (Specify) 12/20/04 EM 21. Signatur of Funeral Service License 22. Name and Address of Facility BENNIE SABEL MD 2/801 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTANO /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 🗌 Yes 2 No i⁴ ☐ N rsing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification; To this 28c. Injury at Work? 27. Manner A Peath 28b. Time of After t 28d. Describe how injury occurred Majural 5 Pending To the hosping within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiel and manner stated. 29b. Son and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohan Bhat 614 Waeternshore Dr Salisbury MD 21804 31. Date filed (Month, Day, Year) DEC 16 2004 32. Registrar's Signature State

Registrar

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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28a-f show	by Funer	11.	Marital Status 1 □ Never Married 2 3 ☑ Widowed 4 □ □	_	12. Was Dec Anned F 1 Yes If Yes, G Year or D	orces? 2 □ No	er in U.S. 1942 - 1946		Vas Dece f Yes, spe		ispanic Origin In, Mexican, F Specify:	n? (Specif Puerto Ric	y Yes or No an, etc.)	0-	14. Race - Black, Specify:			.te
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Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours att oppartment of Health and Mental hygiene.	1	19	a. informant's Name/F Charles J.	Relationship (T) Dillo	vpe, Print) √ / SO1	ı	19	b. Mailin 28	g Address Ren	(Street a	Drive,	or Rural F LaVa	oute Numb	er, City Mary	or Town, Sta land	215		
Ore of He of He		20	a. Method of Disposition		Removal from	State	20b. Place o	ary, crem	natory or c	ther plac	e)	Date			ocation - Cit			
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Division of Vital Re To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director again.	edical C	29	a. Certifier 1 💢 (Check only 2 🗆 N	Certifying Physidedical Exami	ner: On the b	best of nasis of ex	amination ar	e, death	occurred a	at the tim in my op	e, date and pi inion, death o	lace, and occurred a	due to the out the time,	cause(s)	and manne d place, and	r as st	ated. the cause(s	i)
To the To the To the	₩ W	29	o. Signature and the of	t centier	2				29c		number 16041			29d. Da	te signed (N	fonth, I	Day, Year)	-
Q21. Q.3.		30.	Name and address of	Person who co	MMA.	e ol dea	(Item 23a)	(Type. F	Print)	ע	T004T			рес	ember -	20,	, 2004	
824.			Terry wi							enue	, Cumb	erla	nd, Ma	ary l	and 2	2150	02	
	State istrar	31.	Date filed (Month, Day			1	Signature	4		,								
	416.	_	DEC	2 1 20	J4 -	Jens	RF-GJ	1	- fy	pork	2							

			For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of H			iene 2004	41988
	E H.		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	th	3. Time of Death
	Physici /Media		Nancy	Irene	Everett			Decembe	Day Year 218 2004	3:17 a M
2	Examir		4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or	r Location of Death		4c. County of Deat	1
			Calvert Memoria				Frederic		Calvert	
н	Funeral		,	5. Sex 7. A 1 ☐ M 2 💢 F	ge (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Mar 30,	9. Birti Co 1046 Wagi	nplace (State or Foreign untry)
	Director		217-44-6281 Usual Residence of Decedent		30			rai 30,	1940 Wasi	n., D.C.
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	the Marylar 28e-f show	ctor	MD Ca	lvert		Owings				1 ☐ Yes 2 XNo
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	23e	al	105 Delores Dr:	ive		20	0736		USA	
	er dez	Ine	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13. 1	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	s afte	by Funeral	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🔀 No	Specify:		Specify: wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or items 23e or 28e-1 show he Medical Examiner must be rodified at		15. Decedent's		16a Decer	dent's Usual Occup	ation		16b. Kind of Business/	
15	n ne	Completed	(Specify only highest	grade completed)	(Give	kind of work done of DO NOT use retired	during most of working	ng	Too. Kind of Dualitosari	ndustry
212	d with giene or tha	mo	Elementary/Secondary (0-12)	College (1-4or		utician			hairdress	ina
	e file al Hyg othe	Bec	17. Father's Name (First, Middle, L.	ast)			18. Mother's Name	(First, Middle, M		
/lai	Menta Menta arked	To	John Millard	Gray			Dorothy	Marie	Schaeff	er
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-1 show then treumatic event, the Medical Evantinar must be rouffled at		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	ng Address (Street	and Number or Rura	i Route Number,	, City or Town, State, Z	ip Code)
	1 and 2 Health em 27		Walter R. Evere	ett, Jr., s			Drive, Owi			
Baltimore,	Pages 1 nent of H ont: If ite iry or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	3 □Removal from State		natory or other plac	(e)		20c. Location - City or	own, State
tim	t. Pa tmen tent: tent:		`4 □Donation 5 □ Other (Spe				dens 12-22	2-2004	Dunkirk, M	20754
Bal	permit. Pages 1 and Department of Health Importent: If item 27 any njury or other tr once.		21. Signature of Funeral Service Li	R. Sh		Name and Address ausch Fur		e, P.A.,	Owings, M	20736
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	d the death. Do not ent ine.	er the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		espirato	2	Failon			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	0		7		
	Lxammer	<u>.</u>	Sequentially list conditions	D. —	hoonic	Obstruc	tim t	ul mana	y lisea	.
	ed sit	nine	t any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cita to (or as	s a consequence orp:					
•	xecul and	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical E								
687	ficate p phy as the	edic		d.						
Box	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3e			23d. Date of deli-	rery
	death e atte	icia	in the past 12 months?	4□Pregnant a]Ectopic pregnancy] Other (s <i>pecify)</i>			Month	Day Year
P.0	that the deed by the detached	hys	9 Onknown	9□ Unknown						
	res tha igned be def	by F	Part II. Other significant condition	s contributing to death I	out not resulting in the ur	nderlying cause give	en in Part I.		eacco use contribute to	
brd	w requir been si should	ted	-					1 Te	es 2 No 3 Pro	bably 4 Onknown
Records,	e law r has be ge 2 sh	Completed						24a. Was ar autops	v prior to c	opsy findings available ompletion of cause of
<u>=</u>		Con						perform 1 Yes 2	ned? death?	2 No
/ita	ysicien: The is certificate had director, page	Be	25. Was case referred to medical examiner?	Linesite!			26. Place of Death			
of Vital		2	1 Yes 2 No	Hospital: 1 Inpati					nce 6 Other (Spec	fy)
		lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ay Year) 28b. Time of Injury	Work	yat k? Yes 2 □No	esa. Describe no	w injury occurred	
Sic	I or Attendi after death. Director: A	lical	2 Accident investigated and Suicide 6 Could no	t be	iury - At home farm str			98f Location (Str	reet and Number or Rui	al Route Number
Division	el or Att	Certification:	4 Homicide determin	building, e	jury - At home, farm, str tc. (Specify)	50t, 140tory, 511160		City or Town	, State)	a. Frodio Trambol,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best xeminer: On the basis of and manner st	of my knowledge, death of examination and/or invaled.	n occurred at the time restigation, in my op-	ne, date and place, a pinion, death occurre	and due to the ca and at the time, da	use(s) and manner as ate and place, and due	stated. o the cause(s)
	roth within fo the	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month)	Day, Year)
	,- >F 0		> D shah	MD		D	50290		12-19	- 04
			30. Name and address of person w		death (Item 23a) (Type,	Print)				
_	10		Dhiren show	110, +	tosp RD		ina	Freder	vich MD	20678
	Sta Registr		31. Date filed (Month, Day)	2 1 2004 A	Laure K	South s				
						All Property of				

Physic		Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue Registra Perio Tue		r me G84	Certificate baseau	2. Date of D	Reg. No. U 4	3. Time of Death
		Wesley P.				Month DEC.	26, 2004	1854 P M
/Medi Exami		4a. Facility Name (If not institution,	give street and number,)	4b. City, Town, or Location		4c. County of Dea	
		367 FLETCHWOO			ELKTON		CECIL	
Funeral Director		5. Social Security Number 180-58-4213 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birt	thday) If Under 1 Year If Under 1 Year Months Days Hour			thplace (State or Foreign ountry) PA
nyland how		10a. State 10b. County		10c. City, Town	or Location			10d. Inside City Limits
the Marylan 28a-f show notified at	cto	MD Cec:	i 1	E1k				1 ☐ Yes 2 🙀 No
death with the Maryland ms 23a or 28a-f show I must be notified at	Dir.	10e. Street and Number	3 D 3		10f. Zip Code		10g. Citizen of What C	ountry?
death ms 23	era	367 Fletchwo	12. Was Decedent	Ever in U.S.	21921 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic	Origin? (Specify Yes or N	U.S.A	
BAITIMORE, IMARYIANG Z1Z15-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-4 show any injury or other traumatic event. The Madical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexic		Black, Whi	te, etc.
D-C	etec	15. Decedent' (Specify only highest	s Education t grade completed)	16a.	Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired)	lost of working	16b. Kind of Business	/industry
Baltimore, Maryland 2121 Sermit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. mportant: if item 27 is marked other than " more.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			Smuckers	Quality
Hygid Hygid	Be Co	1 2 17. Father's Name (First, Middle, L	ast)	M:	aintenance Wo	orker ther's Name <i>(First, Middl</i> e	Beverage Be, Maiden Sumame)	
lid be Mental Mental rkad tic ev	To B	Simon Er	ngleka		Jay	ne Romesb	era	
and halls ma		19a. Informant's Name/Relationsh	ip (Type, Print)	19b.	Mailing Address (Street and Nun			Zip Code)
and and marking markin		Jessica Engle	eka/Wife	3	67 Fletchwood	Rd. Apt.	5B,Elkto	n,MD 2192
IOFE Iges 1 If Ite or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation		20b. Place of cemeter	Disposition (Name of v. crematory or other place)	December	20c. Location - City or	Town, State
ITIIT iit. Pa artmer artant njury		 4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L 		Memor	n Manor ial Park 22. Name and Address of Fac	2004	Elkto	on, MD
Deperment impo		2 September 1	1 Ali Va		Andrew G. Ge		Home	
(bu, ysician and e burial-transit	cai Examiner	Sequentially list conditions, if any leading terms of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of	d:			
g at cat	Medi	IF FEMALE:	23c. If yes, outcome	of pregnancy				
the death certificate by the attending physicached for use as the lace	hysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of del Month	ivery Day Year
equires that the death certificate signed by the attending ould be detached for use as	۵	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death t time of death	5 ☐ Other (specify)		Month tobacco use contribute to	Day Year
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VICAL RECORDS, P.O. BOX of ician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner?	1 □ Live birth 4 □ Pregnant a 9 □ Unknown 1s contributing to death b	2 ☐ Fetal death t time of death ut not resulting in	5 ☐ Other (specify) the underlying cause given in Par	24a. Was auto perfit 1 X Yes ce of Death Check onl	Month tobacco use contribute to Yes 2 No 3 Pr an psy prior to death? 2 No 1 Yes	Day Year othe cause of death? obably 4 □Unknown topsy findings available completion of cause of 2 □ No
II OI VITAI MECOIDS, P.O. ng Physician: The law requires that the cater this certificate has been signed by the ineral director, page 2 should be detached.	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1□ Yes 2 □ No 27. Manner of Death 1 ☑ Natural 5 Pending	1	2 Fetal death time of death ut not resulting in	the underlying cause given in Par 26. Pla patient 3 DOA	24a. Was auto perful Tip Yes ce of Death Check onl. Nursing Home 5 Resi	Month tobacco use contribute to Yes 2 No 3 Pr an psy prior to death? 2 No 1 Yes	Day Year othe cause of death? obably 4 □Unknown topsy findings available completion of cause of 2 □ No
II OI VITAI MECOIDS, P.O. ng Physician: The law requires that the cater this certificate has been signed by the ineral director, page 2 should be detached.	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? LYes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	2 Fetal death time of death ut not resulting in 2 ER/Out, ry Year) 28b. Ti	the underlying cause given in Par 26. Pla patient 3 DOA Other: 4 Ime of Work?	24a. Was auto perfu perf	Month tobacco use contribute to Yes 2 No 3 Pr an psy prior to death? 2 No one dence 6 Y Other (Spechow injury occurred)	Day Year othe cause of death? obably 4 □Unknown ttopsy findings available completion of cause of 2□ No arrival AT SCENE
II OI VITAI MECOIDS, P.O. ng Physician: The law requires that the cater this certificate has been signed by the ineral director, page 2 should be detached.	ledical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Inju (Month, Date led 28e. Place of Inju building, et	2 Fetal death time of death time of death time of death time of death time of death time of death time of death time of death time of death time of death time of my knowledge, of examination and	the underlying cause given in Par 26. Pla patient 3 DOA ime of jury M 28c. Injury at Work? 1 Yes 2 [24a. Was auto perfu 27 / 28 / 28 / 28 / 28 / 28 / 28 / 28 /	Month tobacco use contribute to Yes 2 No 3 Pr an 24b. Were an province of death? 2 No 1 Yes one dence 6 Y Other (Spectors) occurred Street and Number or Rumn, State)	Day Year othe cause of death? obably 4 □Unknown topsy findings available completion of cause of 2 □ No city) AT SCENE
OI VICAL MECOLOS, P.O. Physician: The law requires that the criticate has been signed by the raid director, page 2 should be detached.	Medical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigated A Homicide	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da 1 Physician: To the best xaminer: On the basis o and manner st.	2 Fetal death time of death time of death ut not resulting in 2 ER/Out, ry year) 28b. Tin ury - At home, fanc. (Specify) of my knowledge, f examination and ated.	the underlying cause given in Par 26. Pla patient 3 DOA patient 3 DOA 28c. Injury at Work? M 1 Yes 2 [m, street, factory, office death occurred at the time, date of investigation, in my opinion, di 29c. License numbe O.C.M.E	24a. Was auto perfusion of the control of the contr	Month tobacco use contribute to Yes 2 No 3 Pr an 24b. Were an province of death? 2 No 1 Yes one dence 6 Y Other (Spectors) occurred Street and Number or Rumn, State)	othe cause of death? othe cause of death? obably 4 □Unknown otopsy findings available completion of cause of 2 □ No othy AT SCENE oral Route Number, stated, to the cause(s) or Day, Year)

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) 2. Date of Dea Month DECEMBE	PRINCE GEORGE'S Year) 9. Birthplace (State or Foreign Country) North Carolina 10d. Inside City Limits 1 Yes 2 No No. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Government Maiden Sumame)
Second S	4c. County of Death PRINCE GEORGE'S Year) 9. Birthplace (State or Foreign Country) North Carolina 10d. Inside City Limits 1 Yes 2 No Og. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Government Maiden Sumame)
S. Social Security Number S. Social Security Number S. Sex 1	9. Birthplace (State or Foreign Country) 1938 North Carolina 10d. Inside City Limits 1 12 Yes 2 100 10g. Citizen of What Country? U. S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Government Maiden Sumame)
Usual Residence of Decedent 10a. State 10b. County MD Prince George's Capital Heights 10c. City, Town or Location Capital Heights 10c. Street and Number 6615 Valley Park Road 11. Marital Status 11. Marital Status 11. Mever Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, sive Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th 17. Father's Name (First, Middle, Last) Willie R. Fryar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number)	10d. Inside City Limits 1 ☑ Yes 2 □ No Og. Citizen of What Country? U. S. A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Government faiden Sumame)
The state of the s	Og. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Government faiden Sumame)
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The state of the s	faiden Sumame)
Willie R. Fryar Page 19 Willie R. Fryar Hattie L. Robin	son
Earnesteen Fox-Fryar/Wife 6615 Valley Park Rd. Capital Ho	City of Tanana City of the Cit
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
Solution 1	20c. Location - City or Town, State
21. Signature of Funeral Ser de Lique 22. Name and Address of Facility J. B. Jenk 7474 Landover Road Landove	ins Funeral Home
23a. Part 1. Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds shock, or heart failure. List only one cause on each line.	st, Approximate
Physician disease or condition Acute Respiratory Failure a. Acute Respiratory Acute Respiratory	Interval Between Onset and Death
Examiner Sequentially list conditions Sequentially list conditions	
Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Severe Encephalopathy Due to (or as a consequence of):	
Severe Encephalopathy Cause, Enter Underlying Cause, Clisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d	
So entitional as the property of the property	
The state of the second program of the secon	23d. Date of delivery Month Day Year
Chronic Renal Failure	acco use contribute to the cause of death? 2 □ No 3 □ Probably 4 Æ Unknown
Diabetes Mellites 24a Was ar autopsy perform 1 Diabetes Mellites	prior to completion of cause of death?
Deform to perform to p	
25. Was case referred to medical examiner? 1	
building etc (Specify)	eet and Number or Rural Route Number, State)
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town, 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town, 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town, 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town, 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town, 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Str. City or Town, 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and (title of certifier y) 29b. Signature and (title of certifier y) 29c. License number 29c. License number	se(s) and manner as stated. e and place, and due to the cause(s)
~ account	d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2/17/04
Revathy Murphy M.D. 6130 Landover Road Cheverly, Maryland 2078 State Registrar Registrar OFC 2 1 2004	

Physician /Medical Examiner		st)					
		e			2. Date of Death Month December	Day Year 15 2004	3. Time of Death 9:03p
	4a. Facility Name (If not institution, given Washington Advent	e street and number) List Hospital	4b. City, Town, Takoma	or Location of Death Park	ресемьет	4c. County of Deed Montgomes	th
Funeral Director	5. Social Security Number 6. St 424–98–3583 Usual Residence of Decedent	ex 7. Age (In yrs. last to 2	birthday) If Under 1 Yea Months Days		8. Date of Birth (Month, Day, Youne 21,		hplace (State or Foreig ountry) abama
death with the Maryland ms 23a or 28s-f ahow LOMAL DE DOLIFTED AT THE TAIL DIRECTOR	Maryland Montgom 10e. Street and Number	ery Silve	r Spring 10f. Zip Code 20903			Citizen of What Co	•
72 hours after death v natural; or items 23a lical Executive count	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22€ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe ban, Mexican, Puerto		14. Race - Ame Black, White Specify:	rican Indian,
filed within 72 hours aff Hygiene Hygiene in ther than "natural", or onf, the Madical Exeminate.	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	de completed) College (1-4or 5+)	a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Sales Repres	during most of workingd)	ng	o. Kind of Business/	Industry
d 2 should be filed the and Mental Hygin 77 is marked other traumatic avent, I To Be CC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Main	den Sumame)	
es 1 an of Heal of Heal if item?	Cherry Flute/Mot1 20a. Method of Disposition 1 Burial 2 Cremation 3 Cherry Specific Specifi	ner 18 20b. Place cemet	3900 Birds E of Disposition (Name of ery, crematory or other pla	ye Drive,	Germantow	m MD 208 Location - City or 1	74 Town, State
Department Pag Department Importent: I any injury o	21. Signature of Funeral Service Licen	Mille	Alexander 5538 Marlb	S. Pope Fu	neral Hor	rmingham, nes	Alabama 20747
Physician /Medical	23a. Part1. Enter the disease, or come shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	not enter the mode of dyi	ng, such as cardiac of	r respiratory arrest,		Approximate Interval Between Onset and Death
cate be executed by sicle and the burial-transit dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence					1
The law requires that the death certificate be tee has been signed by the attending physicit age 2 should be detached for use as the bu ompleted by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	n 3 □Ectopic pregnancy 5 □ Other (specify) □	у		23d. Date of delive	ery Day Year
w requires that been signed I should be deta	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to t	>
W CT (1)					24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Physical distriction of the state of the sta	27. Manner of Death		Time of 28c. Injun	4 □ Nursing Hom		6 ☐Other (Special	ý)
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral medical Certification;	1 Avatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At home, fabuilding, etc. (Specify)	Injury Worl	k? Yes 2 □ No		and Number or Rura	ul Route Number,
dospi 4 hour Funer ely fill	29a. Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination an and manner stated.	e, death occurred at the timed/or investigation, in my o	ne, date and place, an pinion, death occurred			tated.
To the I	29b. Signature and title of certifier	estitoet for M.	P, 29c. License 52		29d. D	ate signed (Month,	
State	30. Name and address of person who con the state of the s	ompleted cause of death (Item 23a) The first of the firs		oll Avenue			20912

State of Maryland / Department of Health and Mental Hygiene 0 0 4 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Maria Francisca Souza December Francisco /Medical 17, 2004 10:40 a^M **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Frederick Prince Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 2 🔀 F Days Hours **Director** Yrs. 217-47-2141 80 Nov 8, 1924 Brazi] Usual Residence of Decedent the Maryland 10a. State r than "naturel", or Items 23a or 28a-f show the Madical Externing the mailtied at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD Calvert North Beach 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filled within 72 hours after death with Innent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 2 4110 3rd Street 20714 Brazil 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 Specify: Braz<u>ilian</u> 1 X Yes 2 □ No Be Completed by Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clothing store owner, seamstress Ith and Mental Hygie 27 Is marked other r treumetic event, II Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leandro ဥ Souza Josefa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important; If item 27 Is eny injury or other treu once. Abigail S. Francisco, daughter 4110 3rd St., North Beach, MD 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 12-20-04 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Oron Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of the Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of) P.O. Box 68760. Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 DEctopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending hours after death. investigation 2 Accident 1 Tyes 2 No Director: 3 Suicide 6 Could not be à Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 033123 30. Name and address o person who complete cative of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D., 110 Hospital Rd., Ste. 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registra Signature State 2 0 2004 Registrar

			1 - For State Registrar	State of Man		artment of		and Mental Hy	/gien Reg. N	CULL	41993
1	Physic	ian	Decedent's Name (First, Middle, Last) SHEYLIK	MOISEYEVIO				2. Date of D Month DECEMBI	eath		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give s				, or Location of			County of Death	12:15 PM
			HOLY CROSS HO	SPITAL			SPRING			MONTGOMER	RY
B	Funeral Director		5. Social Security Number 6. Sex 214-41-4894	M 2 F	yrs. last birthday 82 Yrs.	If Under 1 Yea Months Day		24 Hrs. 8. Date of Bi Min. Month D AUGUS	rth ay, Year	9. Birthp	place (State or Foreign http) JKRAINE
	and		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation					
	Maryl -f sho	tor	MARYLAND MONTGOME		SILVER SI					1	10d. Inside City Limits 1 Yes 2 □ No
	th the or 28a e redi	irec	10e. Street and Number	VI I	STEARY 21	10f. Zip Code			10g. Ci	tizen of What Cour	21
	ath wi	ral	1400 FENWICK LANE,	# 913		2091	0		U	. S. A.	
(0	72 hours atter death with the Maryland natural', or Itams 23a or 28a-1 show disal Evarilinar musi be redified at	Funeral Director	11. Marital Status 1 1 Never Married 2X Married	 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No 	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origi Iban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - Americ Black, White,	
21215-0036	n 72 hours a "natural", or odicul Ever	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2💢 No	o Specify:			Specify: WHI	TE
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212	l withi iene. r than	фшо	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retir	/	מי	SOV	LET UNION	T COV T
ठ	be tiled ntal Hygi ed other avant, t	0)	17. Father's Name (First, Middle, Last)			LBIIIMI I		's Name (First, Middle			GOVI
Maryland	should be nd Mental marked matic av	²	MOISEY FELDMAN				NAHA		KNOV	,	
Ma	nd 2 sh ilth and 27 is r r traun		19a. Informant's Name/Relationship (Typ BORIS S. FELDMAN -	•				or Rural Route Numb			
ore,	of Head		20a. Method of Disposition	2	Ob. Place of Dispo		-	Date		ocation - City or To	
Baltimore,	Page tment tant: Il	ш	1 Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	-	GARDEN OI	F REMEMBI	RANCE 1	2/9/2004	CLA	ARKSBURG,	MARYLAND
Bal	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked to any injury opphar traumatic avoide.	V O	21. Signature of Funeral Service Licensee	Otottlen	nges Ei	Name and Addr DWARD SAC 191 ROCK	ess of Facility JEL FUN VILLE P	ERAL DIRECTION	TION ILLE	N, INC. E, MARYLA	ND 20852
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the cause on each line.	eath. Do not ent	er the mode of dy	ing, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
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	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor							
	icate be executed physician and the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	sequence of);						
8760,	ysicial ysicial	dical	L d.								
		a	IF FEMALE:								
Вох	law requires that the death certific as been signed by the attending p 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	 If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 	Fetal death 3	Ectopic pregnand Other (specify)	Э		1	23d. Date of deliver Month	y Day Year
<u>о</u>	at the de by the a tached f	hysl	1 Yes 2 No 9 Unknown	9□ Unknown							
S,	res that igned to be deta	þ	Part II. Other significant conditions contr		resulting in the ur	nderlying cause gr	ven in Part I.	23e. Did to	obacco u	se contribute to the	e cause of death?
ecords,	w require been si should b	eted	END STAGE RENAL DI	SEASE						□No 3□Proba	bly 4 □Unknown
Rec	0 - 0	Completed	HYPERTENSION					24a. Was autop		24b. Were autop: prior to com death?	sy findings available pletion of cause of
	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26 Place of		2 No	1 ☐ Yes 2	2 No
ot <	this al div	٥	TO 100 EXTIO		2 ER/Outpatien	t 3□ DOA Ott		ing Home 5 Resid		☐Other (Specify)	
on O	ding F h. After tunera	tlon	27. Manner of Death 1 Natural 2 Accident Natural 1 Nestigation	28a. Date of Injury (Month, Day Yea.	r) 28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe h	ow injury	occurred /	
Division	tal or Attanding s after death. al Diractor: After ed in by the tune	Certification	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A	At home, farm, stre		Yes 2 □ No		itreet and	d Number or Rural i	Route Number
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	To tha Hospital o within 24 hours aff To the Funaral Di completely filled in	edical	29a. Certifier (Check only one) 1 Xertifying Physic 2 Medical Examine	ian: To the best of my r: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tile estigation, in my o	me, date and popinion, death o	place, and due to the coccurred at the time, o	ause(s) date and	and manner as stat place, and due to t	ted. he cause(s)
	To the within To the Comp	S	29b. Signature and title of certifier	1	440	29c. Licens	se number	- 2	29d. Date	signed (Month, Da	ay, Year)
	9		· ////	1	MI	D416	62		DECE	MBER 6, 2	2004
	'		30. Name and address of person who come SAEED KRONFLI, M.				# 4.90	TAKOMA DAR	י עום	MADS/T AND	20012
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's Si				TAKOMA PAI	(A)	MAKI LAND	20912
	Registra	r	DEC 14 200	1 Banera	~ 3	Soone	2				

			1 - For State Registrar	State of	Marylan		artment of F rtificate of		nd Mental Hy	giene ()	04	41994
			1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medio		Judy		Ann		Fram	e	12 -	13-	04	10:38p.M.
	Examir		4a. Facility Name (If not institution,	•	-		4b. City, Town, o				ty of Death	
			SACRED HEA	ART 17	05917	AL	CUMB			AL	LEGA	ANY
	Funeral		,	6. Sex 1 □ M 2 □ F	Age (In yrs.		If Under 1 Year Months Days		Hrs. 8. Date of Bir Min. (Month, Da	th ly, <i>Year)</i>	9. Birth	place (State or Foreign intry)
	Director		218-64-7876	1 M 28 F	62	Yrs.			Min. (Month, Da 12/23/	1941	Mai	ryland
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation					10d. Inside City Limits
	shor	ž			100.00							1 ☐ Yes 2 → No
	Ba-f	Director		Legany		Cum	berland			10- 0::	()4/5	
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show diest Exactinet must be natified at		10e. Street and Number 11303 Ore St	reet N F	Ant	3	10f. Zip Code 215	0.2		10g. Citizen o		antry ?
	s 23	Funerai		12. Was Dece					2 (Specify Vac or No			ican Indian,
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36	Ir, or	by	3 Widowed 4 Divorced	If Yes, Give Year or Da	•		1 □ Yes 2 🖺 No	Specify:		Spec	ify:	White
ŏ	2 hou	ed	15. Decedent's	s Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of	Business/li	ndustry
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p	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show avent, the Madical Examinat must be notified at	Be	17. Father's Name (First, Middle, L						Name (First, Middle,			enner
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Baltimore, Maryland 21215-0036	ges 1 and 2 should be it of Health and Mental If Item 27 Is marked or or other traumatic ⊕v		19a. Informant's Name/Relationsh		_				or Rural Route Number			
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Se	of He of He item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Domoval from S		Place of Dispo emetery, crea	osition (Name of matory or other pla	ce)	Date	20c. Location	- City or T	own, State
Ĕ	Page nent ant: I		° 4 □Donation 5 □Other (Sp		MD	Vet. C	em. @ Ro	ckyGap	12/17/200	4 Fli		one, MD
alt	permil. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service L	icensee	^	2:				-		Home, P.A
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			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that co	used the deat en line.	h. Do not en	ter the mode of dyi	ng, such as ca	rdiac or respiratory a	rrest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (c	r as a conseq	uence of):			1			JUTTE
ш	Examiner		Convention list conditions	, a Hetel	-10501	totic	cardo) 20 V (ulat disi	ase		20years
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Ö,	e exe		resulting in death) cast	Due to (d	or as a conseq	uence of):						
8760,	death certificate be executed e attending physician and of for use as the burial-transit	dicai	1	d						<u> </u>		
9	death certifica attending ph d for use as t	Mec	IF FEMALE:									
Вох	ath co	Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	Ideath 3	Ectopic pregnanc	у			ate of deliv	very Day Year
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐ Unkno	int at time of d wn	eath 5	Other (specify) _					,
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S,	es pe	by	10 Parado (1) A Lo	compating to do	atti bat not ros	atting in the a	riconying caase gr	off in Fatti.	10			bably 4 Unknown
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Sic	or Attending after death. Director: After in by the fune	icat	2 Accident investig	ot be	of Injune - At he	ome form of		165 2 140		Street and Num	ther or Pur	al Route Number,
Division	or A after Direction by	Certification:	4 Homicide determin	buildin	g, etc. (Specif	y)	reet, factory, office		City or To		1001 01 1101	arrioble ramber,
	pital ours eral filled		29a. Certifier 1D Certifying	Physician: To the	hest of my kno	wledge deat	h occurred at the ti	me date and r	place, and due to the	cause(s) and n	nanner as	stated
	Hos 24 hc Fun Fun	edical	(Check only 2 Medical E	xaminer: On the ba	sis of examina	ition and/or in	vestigation, in my	pinion, death	occurred at the time,	date and place	, and due	to the cause(s)
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	29b. Signature and title of certifier	and main			29c. Licens	se number		29d. Date sign	ed (Month,	, Day, Year)
			Mangalan	Pina	\sim	h	100	912	,	Decemi		17 64
,	3		30 Name and address of passes	vho completed cause	of death (Item	n 23a) (Tuna	Print)	15)		171 -6"	10, 1	150
	4.3		30. Name and address of person v	1 (2) I	44771	12 7 E.	V CAAD	101=	CUMBER	Myth	MAN	215/1
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	iture	X ICCT!	/V,C	CALIDER	V-1/1	1 (1)	7. vol
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				U. EUV	1		- AFFE	-7-4				

Physicia		1. Decedent's Name (First, Middle		Maryland / D		Dealit	2. Date of De	ath	3. Time of Dea
/Medica	al	Garland 4a. Facility Name (If not institution	Philip Fea		4h Cin Taur		De c embe	r 21, 2004	4:55 A
Examine		Country Mead	lows of Fre	ederick	Frede			4c. County of De Freder	ick
Funeral Director	-	5. 21-9-620+931-48 214-22-732 7	6. Sex 1 M 2 ☐ F	7. Age (In yrs. last birth	Months Days		8. Date of Bird (Month, Da Aug • 20	u l — 19—1926 в у, _{Уеаг)} , 1927 Маг	Sirthplace (State or For Country) 191and
show		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town					10d. Inside City Lin
or 28e-f show	Director	Maryland Freder 10e. Street and Number	1CK	Frederic	10f. Zip Code			10g. Citizen of What (1 □ Yes 2 K
or items 236	<u>a</u>	8127 Cambridge] 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dece	2 🕅 No	21704 13. Was Decedent of If Yes, specify Cull 1 Yes 2 X No		(Specify Yes or No erto Rican, etc.)	Specify:	
e. maturel',	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education	16a. C	Decedent's Usual Occu Give kind of work done life. DO NOT use retire	during most of w	vorking	16b. Kind of Busines	nite s/Industry
al Hygien I other th	Be Con	12 17. Father's Name (First, Middle,	Last)	se1	E	18. Mother's N	ame (First, Middle,	real estat Maiden Sumame)	e/develop
marked metice	0 1	Russell Staley 1 19a. Informant's Name/Relations!		19h A	Asiling Address (Stmo		M. Dutrow	r, City or Town, State,	7. 0. 1.
Department of Health and Mental Hygenes Importent: If item 27 is marked other than any injury or other treumetic event, Item Once.		Sharon Lillard, 20a. Method of Disposition		760:	San-di-ga	an Drive			.702
tent of		1 X Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (St		tate cemetery,	crematory or other pla vet Cemete:		7/2004	Frederick,	
Departing any inju		21. Signature of Funeral Service I	9	✓M00999	Keeney and Address and 106 East	d Bastor Church S	d PA Fune	eral Home	21701
hysician /Medical		23a. Part 1. Enter the disease, or shock, of heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Emphy	ch line.	t enter the mode of dyi	ng, such as cardi	ac or respiratory an	rest,	Approximate Interval Betweer Onset and Deatl 2 Years
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day December 24, **Physician** Leona Mabe1 GRAHE 1400 p.m. 2004 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17408 West Washington Street Hagerstown Washington If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Hours Min. Dec. 8, 1916 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign Country) Delaware 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Days Months 1 ☐ M 2 ☑ F 88 Yrs. 212-12-4785 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with tha Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 200No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 17408 West Washington Street 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 6 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: white þ 3 Widowed 4 Divorced Year or Dates: Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) schools teacher Baltimore, Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental on 27 is marked or Milton DeWitt Fisher Texie Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17408 West Washington Street, Hagerstown, Maryland Wilbur H. Grahe - husband Department of Heal Important: if Item 2 any injury or other price. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial Park Dec 29,2004 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical ATHEROSCIERO 34 S UL KNEW! Examiner Due to (or es a consequence of): Physician/Medical Examiner The law raquires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. Due to (or as e consequence of) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably þ 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of cause of deeth? 1 Yes O No 1 Tes certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check enly one) 1 ☐ Yes No Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide edical 29a. Certifier (1) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title Medical Campus Rd. Hagerstown 31742 cause of death/(Item 23e) (Type, Print) 1.1110 32. Registrar's Signature Registrar

DHMH 16 Rev 6/95

1- State of Maryland / Department of Health and Mental Hygiene Old 4 997												
	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death									
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of De							
	LAGITIT	*	Calvert Memorial Hospital Prince Freder		1100 0.41	vert						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F	Irs. 8. Date of Birth	9.5	Sirthplace (State or Foreign						
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	pr ,		Usual Residence of Decedent	1-1-1-1		diffornia						
	anylau show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits						
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	er de Itam Der n	- F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	' (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian, hite, etc.						
21215-0036	hours after death with the Maryland tural', or Itams 23e or 28e-f ahow al Examinar must be notified at	by F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Year or Dates:		Specify:	white						
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	and lealth m 27 her tr		Mark Kevin Jennings, husband 9201 Owings Manor Ct		MD 2073	6						
Baltimore,	ges 1 t of H If ita or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	Date 2	Oc. Location - City of	or Town, State						
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3aj	permit Depar Impor any in		21. So, ature of Funeral Service License 22. Name and Address of Facility									
	40 = e d		Rausch Funeral Ho	ome, P.A.,	Owings, 1	MD 20736						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or head allure. List only one cause on each line.	liac or respiratory arre	st,	Approximate Interval Between						
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Box	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	elivery						
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ord	w requir been si should I			2 No 3 Probably 4 Unknown								
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	ro th within rompl	Me	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Mon	th, Day, Year)						
)			1) 002 718	9	12.20	.04						
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									
-)		ZADIR YOUSAF M.D. 2417 Solomus Island Rd Hu	Ntinatown	Md. 200	39						
	Stat	te	31. Date filed (Month, Day, Year) 32. Registry's Signature DEC 2 1 2004 Management of April 1985 A		7							
	Registra	ar	DEC 2 1 2004 December to South									

			1 - For State Registrar AVEND#20b, operFF	State of Marylan					ene 200	14 41998			
1	Dhysiai	.:	Decedent's Name (First, Middle, Last)		2. Date of Death Abouth Day 3. Time of Death								
	Physici /Medio		Marie Myrtha Guil	45 Oth T-	150000000000000000000000000000000000000	14, 2004 6:10 P M							
	Examir	er	4a. Facility Name (If not institution, give st Montgomery Hospic		,	4b. City, Town, or Rockvi		.n	4c. County of				
	Funeral	*	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth). Birthplace (State or Foreign Country)			
	Director		591-24-4100	M 2/E) F	0 Yrs.	William Bayo	110013	Feb. 27,	1954	Haiti			
	/land	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limits			
	a-f sh		Maryland Montgome	ry	lney					1 ☐ Yes 2X No			
	or 28		10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?			
	s 23£	eral	18519 Denhigh Ci	rcle 2. Was Decedent Ever in U.	c 12 V	20832 Vas Decedent of Hi	enanic Origin? /	Specify Vas as No	USA	American Indian.			
036	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural, or items 23c or 28a-f show atte event, the Medical Event art rust be redified at	To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:) If	Yes, specify Cuba	Specify:	to Rican, etc.)		White, etc.			
ည်	72 ho		15. Decedent's Educi (Specify only highest grade			ent's Usual Occupa		rkina 1	6b. Kind of Busi	ness/Industry			
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ς σ	filed v Hygie other t		17. Father's Name (First, Middle, Last)	4	Nu	ırse	18. Mother's Na	me (First, Middle, Ma	Hospit (aiden Sumame				
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental aumatic event.		Unknown					Gillaume					
ary	and N is mai		19a. Informant's Name/Relationship (Typ	e, Print) Husband	19b. Mailin	g Address (Street a	and Number or R	ural Route Number,	City or Town, St	ate, Zip Code)			
	and 2 lealth m 27 her tra		Michel Martin Jacques Je			9	Circle,	Olney, M					
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☎ Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	moval from State	emetery, crem E tonevi EWN Ceme		200	ember 18 R	ckville,	illo, Maryland			
Bail	permit Depart Impor any in		21. Signature of Funeral Service Licenses	Cole	50	00 Univer	sity Blv	Funeral	ver Spr	ing, MD 20901			
В	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
			Immediate Cause (Final disease or condition resulting in death) Brain Tumor										
				Due to (or as a consequ	rence or):								
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	To Troil	Σ	29b. Signature and title of certifier			29c. License D356		290	-	Month, Day, Year) r 15, 2004			
	15		30 Name and address to	related entre of death //r-	232) / 7: 5	Print							
			30. Name and address of person who com Joseph Kaplan, M.D				, Rockvi	.11e, Md 2	0855				
	Sta	te	31. Date filed (Month, Day, Year)	32. Pegistrar's Signat		Sparks		· · ·					
h	Registr	ar	DEC 16 2004	1	1	poures							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:25 pm Galloway)orothy 12 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hunder 1 Year Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year)

Days Hours Min. April 14 Medical Center Arundol 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 25√F 1922 82 Maryland Director 216-38-7220 Usual Residence of Decedent the Manyland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, Ite Madical Examination and once. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 XYes 2 □ No Funeral Director Maryland Anne Arundel
10e. Street and Number Annapolis 10f. Zip Code 10g. Citizen of What Country? 21401 Gilmer Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 CNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: Black ģ 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Family Domestic 5th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lettie Gray Frank Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1010 Tyler Ave. Annapolis, Md. 21403 Ann Herbert (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hill Crest Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal Irom State 12/18/04 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Wm. Reese & Sons Mortuary,
821 West St. Annapolis, Md 21. Signature of Funeral Service Licensee P.A. 21401 Larry Zanny H, Reese & Sons Mortua 821 West St. Annapolis, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Fibrillation **Physician** Ventricular /Medical Due to (or as a consequence of): Examiner Cardiovasimlar Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed Hypertension

Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Division of Vital Records. P.O. Box 68760. signed by the attending physician I be detached for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 1 Yes 2 No Hospital or Attanding Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2X ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054704 12/14/04 30. Name and address of person who completed cause of death (Itom 23a) (Type, Print) 711 Quarterfield Rd, Glen Burnie MD 20061 Marhnez Lisa 31. Date filed (Month, Day, Year) Registrar's Signature State DEB 1 6 2004 Registrar

			1 - For State Registrar	State o	f Marylar		artment rtificate		ealth and I Death	Mental Hy	giene Reg. No	.וחחג	420	00
	Physici	an	Decedent's Name (First, Middle Seymour	e, Last)	COLT	BERG				2. Date of De Month Decemb	eath Day	yı, 2002	3. Time of 2:20	
	/Medic	al	4a. Facility Name (If not institution	n, give street and nu		DERG	4b. City, T	own, or	Location of Death		4c.	. County of Dea	th	
			Suburban H					ethe	sda If Under 24 Hrs.	122. (2)		Montgomery		-
	Funeral Director		5. Social Security Number 111-18-7844	6. Sex 1√2 M 2 ☐ F	7. Age (In yrs. 76	Yrs.		Days	Hours Min.		th ay, Year)	928 Nev	thplace (State ountry) York	or Foreign
			Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or L	ocation					-1	10d. Inside C	ity Limits
	Maryla -f shov	tor		ntgomery	100. 0.	ny, rount of L	Silve	r Sp	ring					2 No
	or 28a	by Funeral Director	10e. Street and Number				10f. Zip (Code			_	izen of What C	-	
	eath wis 23s	eral	1612 Peacock I		edent Ever in U	1 9 13	Was Decede		904	Specify Yes or N		ted Sta		
ď	after d	Fun	Armed Forces? 1 □ Never Married 2 □ XMarried 1 □ Yes 2 □ No					spanic Origin? (S n, Mexican, Puert Specify:	to Rican, etc.)	Rican, etc.) Black, White,				
003	ural', o	d by	3 Widowed 4 Divorced	Year or Dates: WW LL A					Specify: white					
Baltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilh and Mental Hygiene. Department of Heatilh and Mental Hygiene. To proport the 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once.	Completed	(Specify only higher (Elementary/Secondary (0-12)	nt's Education est grade completed) College (1	leted) [ege (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of workin, life. DO NOT use retired) Professor				rking	University of Maryland				
2	e filed Il Hygid other	Be Co	17. Father's Name (First, Middle,	,					18. Mother's Nar		, Maiden	-		
2	ould be Menta	ToE	Benjamin (-		ence Coh				
N	od 2 sh lth and 27 is m		19a. Informant's Name/Relations Lillian Goldbe							ral Route Number, City or Town, State, Zip Code) ver Spring, MD 20904				
9	of Heal		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation		20b.	Place of Disponentery, cre				Date		ocation - City or		
į	Trant:		' 4 □ Donation 5 □ Other (S	Specify)		1wood				12/04			LI, NY	
<u> </u>	Depar Impo		21. Signature of Fymeral Service	Licensee	5			-	Hebrew 1 St., N				20012	
		Г	23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that c	caused the dea							.o., Do	Approxima Interval Be	tween
0	Physician		Immediate Cause (Final disease or condition resulting in death)	a. T-ce	al lym,	phoma							Onset and	
	/Medical Examiner			Due to	(or as a c b hse	uence of):								
Ě	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
mon	vate be executed only sician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):								
8760	te be e ysiciar ne buri	cai		d										
-+ 4	death certifical	/Med	IF FEMALE:	23c If yes ou	tcome of pregn	2004								
10/11	that the death certificated by the attending place of the control	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live b	birth 2 ☐ Feta nant at time of a	al death 3[□Ectopic pre					23d. Date of de Month	Day	Year
700	at the at the lby the stached	Phys	9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
الم الم	signed bed b	by	Part II. Other significant conditi	ons contributing to a	leath but not re	suiting in the L	inderlying ca	use give	en in Part I.			1	robably 4	
eymour	The law requires that the tee bas been signed by the bage 2 should be detached.	Completed								24a. Was	an	24b. Were a	utopsy findings completion of	available
7	vician: The lav certificate has rector, page 2	Com							.,	auto perfo 1 🗆 Yes	psy ormed? 2 No	death?	2 □ No	Cause of
C.	Physician: this certific	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No		Inpatient 2] FB(0 +		A Othe	200	ath (Check only		a = 0.11	- ()	
5	ding Phys h. After this funeral dia	n: To	27. Manner of Death	28a. Date		ER/Outpatie 28b. Time of Injury		Bc. Injury Work	4 🗀 Nursking i	lome 5 Res			эспу)	
bergi	Attending r death. Sctor: After oy the fune	catio	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation not be			М	1 🗆 `	Yes 2 □ No	006	(24	nd Number or R	/ D Ab	
be in	after of At Direct In by	Certification:	4 Homicide determ	nined 286. Place	e of Injury - At h ling, etc. (Speci	ify)	геет, тастогу,	office		City or To			urai noute ivui	nper,
Goldberg	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the I Examiner: On the b and man	e best of my kn pasis of examination	owledge, deal ation and/or in	th occurred anvestigation,	it the tim	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s)) and manner a d place, and du	s stated. e to the cause(s)
6	To th within To th	Me	29b. Signature and title of certifier 29c. License number							29d. Date signed (-		
	6		p Land	<u>MD</u>	no of d==4: 4:	m 02-1 CT		0060	ou /		Decar	mber 11	, 2004	
	Ψ		30. Name and address of person	who completed caus MD 990	se or death (Ite	l Certe	Y DYIX	e,	Rockville	, WB 20	1450			
		atė	31. Date filed (Month, Day, Year DEC 14	32.	egistrar's Sign		Spa	eks	/					
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